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92-421

No. _____

Supreme Court, U.S.
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IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1992

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RICHMOND MEMORIAL HOSPITAL,

*Petitioner,*

*v.*

TAJA SMITH, an infant who sues by and through her next friend and mother, Connie Elizabeth Smith, and CONNIE ELIZABETH SMITH, individually,

*Respondents.*

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# PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF VIRGINIA

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## QUESTIONS PRESENTED

1. Whether a cause of action upon which relief may be granted exists under the federal patient-dumping statute, 42 U.S.C. § 1395dd, for the transfer of an expectant mother from one hospital to another where she did not present to the emergency room of the hospital, she was admitted to the hospital and treated for five days as an inpatient, she was initially stabilized, and she was transferred to a hospital with a neonatal intensive care unit some twenty minutes away because her condition had begun to deteriorate?

2. Whether the federal patient-dumping statute, 42 U.S.C. § 1395dd, preempts notice of claim and malpractice review panel provisions under state law?

## LIST OF PARTIES

The parties to the proceeding below were petitioner Richmond Memorial Hospital, which was the defendant - appellee, and respondents Taja Smith and Connie Smith, who were the plaintiffs - appellants.

## RULE 29.1 LIST

The petitioner Richmond Memorial Hospital, a non-profit corporation organized under the laws of the Commonwealth of Virginia, is owned by Health Corporation of Virginia. Richmond Memorial Hospital does not own any subsidiaries.

## TABLE OF CONTENTS


Page

QUESTIONS PRESENTED . . . . . i

LIST OF PARTIES . . . . . ii

RULE 29.1 LIST . . . . . ii

OPINIONS BELOW . . . . . 2

JURISDICTION . . . . . 2

STATUTES INVOLVED . . . . . 3

STATEMENT OF THE CASE . . . . . 4

REASONS FOR GRANTING THE WRIT . . . . . 18

I. THE FEDERAL PATIENT DUMPING STATUTE DOES NOT APPLY TO THE TRANSFER OF AN INPATIENT WHO DID NOT PRESENT TO THE HOSPITAL'S EMERGENCY DEPARTMENT AND WHO WAS ADMITTED, STABILIZED AND TREATED FOR FIVE DAYS PRIOR TO HER TRANSFER TO ANOTHER HOSPITAL BASED ON MEDICAL NECESSITY . . . 21

II. THE NOTICE OF CLAIM AND PANEL REQUIREMENTS OF VIRGINIA'S MEDICAL MALPRACTICE ACT ARE NOT PREEMPTED BECAUSE THEY DO NOT DIRECTLY CONFLICT WITH ANY REQUIREMENT OF COBRA . . . . . 49

CONCLUSION . . . . . 54

APPENDIX

Opinion and Judgment of Supreme Court of Virginia . . A-1

Letter Opinion of Circuit Court of City of Richmond . . . . . B-1

Order of Circuit Court Court of City of Richmond . . . . . B-20

Supreme Court of Virginia Order Denying Petition for Rehearing . . . . . C-1

42 U.S.C. § 1395dd (1988) . . . D-1

Va. Code Ann. § 8.01 - 581.2 (Repl. Vol. 1992) . . D-16

Department of Health and Human Services, Health Care Financing Administration, Statement on Enforcement of the Anti-Dumping Provisions

of Section 1867 of the Social Security Act (Jan. 1992) . . . . . E-1

American Hospital Association, Medicare Requirements for Emergency Services and Transfers (Oct. 1990) . . . . F-1

American Hospital Association Letter to Ms. Wilensky, Administrator, Health Care Financing Administration (July 9, 1990) . . . . . G-1

Letter from Ms. Wilensky, Administrator, Health Care Financing Administration to Mr. Rettig (Sept. 17, 1990) . H-1

Department of Health and Human Services Letter to Mr.Hodges (Aug. 14, 1990) . . . . . I-1

## TABLE OF AUTHORITIES

Page No.

**Cases:**

*Arlington Yellow Cab Co. v. Transportation, Inc.*, 207 Va. 313, 149 S.E.2d 877 (1966) . . . . . 7

*Bowman v. State Bank of Keysville*, 229 Va. 534, 331 S.E.2d 797 (1985) . . . . . 7

*Bryant v. Riddle Memorial Hospital*, 689 F. Supp. 490 (E.D. Pa. 1988) . . . . . 4

*Burrows v. Turner Memorial Hospital, Inc.*, 762 F. Supp. 840 (W.D. Ark. 1991) . . . . . 52

*Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984) . . . . . 48

*Cox Broadcasting Corp. v. Cohn*, 420 U.S. 469 (1975) . . . . . 13, 14, 15, 16

*Crandon v. United States*, 494 U.S. 152 (1990) . . . . . 40

*Deberry v. Sherman Hosp. Ass'n*, 741 F. Supp. 1302 (N.D. Ill. 1990) . . . . . 24

*Draper v. Chiapuzio*, 755 F. Supp. 331 (D. Or. 1991) . . . 52

*Erlenbaugh v. United States*, 409 U.S. 239 (1972) . . . . . 40

*Evitt v. University Heights Hosp.*, 727 F. Supp. 495 (S.D. Ind. 1989) . . . . . 28

*Glisson v. Loxley*, 235 Va. 62, 366 S.E.2d 68 (1988) . . . . . 50

*Goodyear Atomic Corp. v. Miller*, 486 U.S. 174 (1988) . . . . . 14, 15

*HCA Health Services of Indiana, Inc. v. Gregory*, 596 N.E.2d 974 (Ind. App. July 30, 1992) . . . . . 20

*Helton v. Phelps County Regional Medical Center*, 1992 WL 174298 (E.D. Mo. July 24, 1992) . . . . . 20

*Johnson v. University of Chicago Hosp.*, 774 F. Supp. 510 (N.D. Ill. 1991) . . . . . 24

*Lyons v. Grether*, 218 Va. 630, 239 S.E.2d 103 (1977) . . . . . 46

*Owens v. Nacogdoches County Hosp. Dist.*, 741 F. Supp. 1269 (E.D. Tex. 1990) . . . . . 24

*Petrovics v. Prince William Hosp. Corp.*, 764 F. Supp. 415 (E.D. Va. 1991) . . . . . 28

*Sorrells v. Babcock*, 733 F. Supp. 1189 (N.D. Ill. 1990) . . . . . 4

*Southland Corp. v. Keating*, 465 U.S. 1 (1984) . . . . . 15, 16

*Stewart v. Myrick*, 731 F. Supp. 433 (D. Kan. 1990) . . . . . 28

*Stuart Circle Hospital v. Curry*, 173 Va. 136, 3 S.E.2d 153 (1939) . . . . . 47

*Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131 (6th Cir. 1990) . . . . . 4, 25, 28

*Wilson v. Atlanticare Medical Center*, 868 F.2d 34 (1st Cir. 1989) . . . . . 52

**Statutes and Legislative Materials:**

28 U.S.C. § 1257 . . 2, 12, 14, 16

42 U.S.C. § 1395dd (1988) . . . . . *passim*

Va. Code Ann. § 8.01-581.1 (Repl. Vol. 1992) . . . . . 50

Va. Code Ann. § 8.01-581.2 (Repl. Vol. 1992) . . . 6, 12, 50

Va. Code Ann. § 8.01-581.9 (Repl Vol. 1992) . . . . . 12, 51

H.R. Rep. No. 99-241, 99th Cong., 2nd Sess. *reprinted in* 1986 U.S. Code Cong. & Admin. News 579 . . . . . 41, 44

H.R. Rep. No. 99-241, 99th Cong., 2nd Sess. *reprinted in* 1986 U.S. Code Cong. & Admin. News 726 . . . . 41, 43

131 Cong. Rec. S13903 (Oct. 23, 1985) . . . . . 42

131 Cong. Rec. S13904 (Oct. 23, 1985) . . . . . 42, 45

**Other Authorities:**

C. Koch, Administrative Law & Practice § 3.53 (1985) . . . . . 48

Frew Consulting Group, Ltd., "HCFA Issues COBRA Enforcement Policies," *Critical Information Resource* (March 1992) . . . . . 33

2 J. Moore, J. Lucas, H. Fink & C. Thompson, Moore's Federal Practice ¶ 3.09[2] n.15 (2d ed. 1991) . . . . . 53

**IN THE SUPREME COURT**
**OF THE UNITED STATES**

**OCTOBER TERM, 1992**

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**RICHMOND MEMORIAL HOSPITAL,**

**Petitioner,**

**v.**

**TAJA SMITH, an infant who sues by and through her next friend and mother Connie Elizabeth Smith, and CONNIE ELIZADETH SMITH, individually,**

**Respondents.**

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# PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF VIRGINIA

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The petitioner Richmond Memorial Hospital respectfully prays that a writ of certiorari issue to review the judgment and opinion of the Supreme Court of Virginia, entered in the above-entitled proceeding on April 17, 1992.

## OPINIONS BELOW

The opinion of the Supreme Court of Virginia is reported at 243 Va. 445, 416 S.E.2d 689 (1992) and is reprinted in the Appendix hereto at A-1.

The letter opinion of the Circuit Court of the City of Richmond (Harris, J.) is not reported. It is reprinted in the Appendix hereto at B-1.

## JURISDICTION

The date of the entry of judgment sought to be reviewed in this case is April 17, 1992. On June 5, 1992, the Supreme Court of Virginia denied Richmond Memorial Hospital's timely petition for a rehearing.

The jurisdiction of this Court to review the judgment of the Supreme Court of Virginia is invoked under 28 U.S.C. § 1257(a).

## STATUTES INVOLVED

The statutes at issue in this case are 42 U.S.C. § 1395dd (1988) and Va. Code Ann. § 8.01-581.2 (Repl. Vol. 1992) which are set forth verbatim at D-1 and D-16, respectively, in Appendix D attached hereto.

## STATEMENT OF THE CASE

The plaintiffs-respondents, Taja Smith, an infant suing by and through her next friend and mother Connie Smith, and Connie Smith, individually, brought this action on July 17, 1990 in the Circuit Court of the City of Richmond alleging a violation of the Emergency Medical Treatment and Women in Active Labor provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA), 42 U.S.C. § 1395dd (the "Act"),[1] commonly referred to as the "patient dumping" or "anti-dumping" statute. The motion for judgment contained no other counts.

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[1] The courts have held that state and federal courts have concurrent jurisdiction over COBRA patient dumping claims. See, e.g., Thornton v. Southwest Detroit Hosp., 895 F.2d 1131, 1133 (6th Cir. 1990); Sorrells v. Babcock, 733 F. Supp. 1189, 1192 (N.D. Ill. 1990); Bryant v. Riddle Memorial Hosp. 689 F. Supp. 490, 493 (E.D. Pa. 1988).

The patient dumping statute creates a private cause of action where an individual who has an emergency medical condition or is in active labor presents at a hospital emergency department and is refused a medical screening or is discharged or transferred without stabilizing treatment. § 1395dd(a). Transfers made in the best interest of the patient do not violate the statute. § 1395dd(c). No private remedy exists under the patient dumping statute for the transfer of a patient by the hospital unless such transfer directly results in personal harm to the plaintiff. § 1395dd(d)(3)(A).

On August 21, 1990, defendant-petitioner Richmond Memorial Hospital (the "Hospital") filed a demurrer on the grounds that the motion for judgment failed to state a cause of action under the Act, that

the plaintiffs failed to allege that indigency was the motivating reason for Connie Smith's transfer to another hospital, and that plaintiffs failed to give notice of their claims to the Hospital as required by § 8.01-581.2 of the Virginia Medical Malpractice Act.

On October 9, 1990 a hearing was held on the demurrer. On March 8, 1991, the trial court sustained the demurrer on the ground that while the facts alleged may have stated a common law cause of action for medical malpractice, they failed to state a cause of action for patient dumping under 42 U.S.C. § 1395dd. App. B 15, 18-20. The trial court held that the notice of claim provision of the Virginia Medical Malpractice Act was preempted by the federal Act. App. B 14-15.

The following facts were pleaded in plaintiffs' motion for judgment.[2] On July 18, 1988, plaintiff Connie Smith was admitted to Richmond Memorial Hospital as an inpatient with premature rupture of the membranes. Motion for Judgment, ¶¶ 1 and 2. On that same date it was determined by sonogram that the gestational age of the unborn child was approximately 33 weeks. Id. ¶¶ 3 and 4. Connie Smith received treatment at the Hospital for five days from July 18 to July 23. Id. ¶¶ 18 and 19. The Hospital did not refuse Connie Smith treatment, but rather treated and

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[2] Under Virginia law, the facts alleged in the motion for judgment are admitted for purposes of the Hospital's demurrer, Bowman v. State Bank of Keysville, 229 Va. 534, 536, 331 S.E.2d 797, 798 (1985), but allegations which represent legal conclusions are not admitted, Arlington Yellow Cab Co. v. Transportation, Inc., 207 Va. 313, 318-19, 149 S.E.2d 877, 881 (1966).

stabilized her. Transcript of Demurrer Hearing at 44.

During the afternoon and evening of July 22, Connie Smith's condition began to worsen. Motion for Judgment, ¶¶ 6 - 11. The leakage from her vagina turned from greenish yellow to dark green, and she complained of abdominal cramping. Id. ¶¶ 6 and 10. At midnight she was one centimeter dilated. Id. ¶ 11.

Personnel at Richmond Memorial Hospital consulted with Dr. Jones, Mrs. Smith's on-call obstetrician, by telephone at 10:00 p.m. on July 22 and at 1:00 a.m. on July 23 regarding her condition. Id. ¶ 21. Dr. Jones gave the order for Connie Smith's transfer to the Medical College of Virginia Hospital ("MCV"). Id. ¶ 22. Richmond Memorial Hospital does not have a Neonatal Intensive Care Unit and did not

have the facilities to care for a premature infant such as Taja Smith under the circumstances of this case. Id. ¶ 5.

At 2:10 a.m. on July 23, Connie Smith left the Hospital by ambulance and was transported to MCV. Id. ¶ 19. She was admitted to MCV at approximately 2:30 a.m. Id. ¶ 23. Shortly after admission to MCV she remained dilated one centimeter. Id. ¶ 30. Taja Smith was delivered by Cesarean operation at MCV at approximately 9:48 a.m. on July 23, 1988, more than seven-hours after her arrival there. Id. ¶ 42.

Both at birth and thereafter, Taja Smith experienced multiple health problems. Id. ¶¶ 45-60. Taja Smith remains permanently impaired as a result of birth-related injuries. Id. ¶ 60. Connie Smith also suffered physical injuries in connection with the birth of her child.

Id. ¶ 70. At all times pertinent hereto, Connie Smith was covered by health insurance. Transcript of Demurrer Hearing at 44.

Respondents appealed from the trial court's ruling sustaining the Hospital's demurrer, and the Hospital assigned cross-error to the trial court's ruling that the Virginia notice of claim provisions which pertain to suits against health care providers are preempted by COBRA. App. A 1, 7-8. The Supreme Court of Virginia held that a claim may be stated under COBRA despite the fact that the plaintiff did not present to the emergency room of the Hospital, was stabilized by the Hospital, and received treatment as a patient in the Hospital for five days prior to being transferred to a hospital with a neonatal intensive care unit. The court held that

subsection (c) of the Act dealing with the appropriateness of the transfer of a patient applies to all hospital patients without regard to the limitations imposed by Congress in subsection (a) which make the statute applicable to individuals presenting to the emergency department of a hospital who are determined to be in an emergency medical condition or in active labor. App. A, 17-18.

The court also ruled that the notice of claim provisions of the Virginia Medical Malpractice Act are preempted by the federal COBRA statute because they conflict with the two year statute of limitations prescribed for COBRA actions by 42 U.S.C. § 1395dd(d)(3)(C). App. A, 30-34. Under the notice of claim provisions, a plaintiff may not file suit until 90 days after written notification is provided to the

health care provider and, if the provider requests review by a malpractice review panel, until the panel completes its review. Va. Code Ann. § 8.01-581.2(A). Although § 8.01-581.9 of the Medical Malpractice Act tolls the "applicable statute of limitations" for a period of 120 days from the date notice is given or 60 days following the issuance of any opinion by the medical review panel, the Supreme Court of Virginia, relying upon a federal district court decision, held that these tolling provisions can not toll the statute of limitations prescribed by COBRA which creates a federal right of action. App. A, 33-34.

The court remanded the case for further proceedings. App. A-35. While 28 U.S.C. § 1257 (a), upon which jurisdiction is premised in this case, refers to

"[f]inal judgments or decrees rendered by the highest court of a State," this Court has in the past adopted a pragmatic approach to ascribing finality and reviewability to various situations where further lower court proceedings are contemplated but a federal issue has been finally determined and important federal concerns are at stake.

In Cox Broadcasting Corp. v. Cohn, the Court recognized four exceptions to the general finality rule. 420 U.S. 469, 477-78 (1975). Cases in the fourth category include situaticns where although a federal issue has been finally decided by the state court, there are further proceedings pending in which the party seeking review might prevail on the merits on nonfederal grounds, rendering review of the federal issue by the Court unnecessary, and where

reversal of the state court on the federal issue would end further litigation on the relevant cause of action. In such circumstances, where a refusal immediately to review the state court decision could seriously erode federal policy, this Court has entertained the federal issue. Id. at 482-83.

Applying the fourth exception in Cox Broadcasting, the Court has found finality in cases where further proceedings are contemplated. Following its "pragmatic approach," the Court found that the Ohio Supreme Court's holding that the Atomic Energy Act of 1954 did not preempt Ohio from applying workers' compensation safety requirements to accidents at nuclear facilities was a final judgment under 28 U.S.C. § 1257. Goodyear Atomic Corp. v. Miller, 486 U.S. 174, 180 (1988). In

Goodyear, the Court concluded that the unreviewed decision of the state supreme court would seriously erode federal policy in the area of nuclear power regulation and influence the regulation of federally owned nuclear power plants in states other than Ohio.

The Court also found the California Supreme Court's decision in Southland Corp. v. Keating, 465 U.S. 1 (1984) to be final within the meaning of the fourth exception in Cox Broadcasting. The state supreme court had held that claims under the California Franchise Investment Law were not arbitrable, and that the Federal Arbitration Act did not preempt the state statute. Id. at 6. This Court stated that if the California decision were to remain in effect, it would nullify contracts to arbitrate and seriously erode the federal

policy promoting arbitration of disputes. Id. at 7.

The instant case is reviewable under 28 U.S.C. § 1257 as a final decision of a federal issue because it is similar to those cases found to fit within the fourth category in Cox Broadcasting. First, without immediate review of the Virginia Supreme Court's decision, the Court may not have a future opportunity to pass on the federal issue in dispute. On remand, the Hospital may prevail on nonfederal grounds. The COBRA statute provides inter alia that an individual who suffers harm as the direct result of a participating hospital's violation of its requirements may obtain "those damages available for personal injury under the law of the State in which the hospital is located," § 1395dd(d)(3)(A), and that State or local law

requirements for suit are not preempted unless the requirement directly conflicts with the COBRA requirements, § 1395dd(f). Second, reversal of the Virginia Supreme Court's decision would terminate the litigation.

Finally, without review, the Virginia Supreme Court's interpretation of 42 U.S.C. § 1395dd would remain in effect and would seriously erode federal policy by extending the requirements of the Act beyond its language and its purpose, which is to ensure treatment of individuals who present to hospital emergency departments. All of the hospitals in the Commonwealth of Virginia would be subject to suit for claims which are not addressed by the COBRA statute and which constitute nothing more than traditional medical malpractice claims. It is not, and never has been, a

federal policy to usurp state regulation of medical malpractice law. This holding if left unreviewed will impinge upon important issues of federal-state comity.

## REASONS FOR GRANTING THE WRIT

A writ of certiorari should be granted in this case because the Supreme Court of Virginia has wrongly decided an important question of federal law involving the reach of the federal patient dumping statute, 42 U.S.C. § 1395dd, which has not been, but ought to be, settled by this Court. The Virginia court held that the subsections of § 1395dd do not have to be read in light of one another and that this refusal to treat statute has application to any inpatient transferred by a hospital regardless of whether that individual ever presented to the emergency room of a Medicare

participating hospital or whether the hospital did in fact admit, treat and stabilize the patient. This opinion conflicts with the literal language of the Act, the clearly expressed intent of Congress, accepted principles of statutory construction, the interpretation of the federal agency charged with enforcing the statute, and, in principle, with the decisions of numerous courts holding that the COBRA statute does not extend to claims alleging misdiagnosis or inadequate treatment, which are essentially traditional medical malpractice claims.

As a result hospitals in Virginia are subject to suit for claims allegedly based on COBRA which are not in fact covered by the COBRA statute. In addition, the Virginia Supreme Court's decision deprives these hospitals of safeguards, such as

notice of claim and medical review panel provisions, enacted by the state legislature in order to protect health care providers from meritless suits and to contain the skyrocketing cost of malpractice insurance. Finally, courts outside of Virginia, some of which have already cited the Smith decision approvingly,[3] may also misinterpret the reach of the federal patient dumping statute based on the Virginia Supreme Court's rationale.

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[3] See, e.g., HCA Health Services of Indiana, Inc. v. Gregory, 596 N.E.2d 974 (Ind. App. July 30, 1992); Helton v. Phelps County Regional Medical Center, 1992 WL 174298, *4 (E.D. Mo. July 24, 1992).

## I. THE FEDERAL PATIENT DUMPING STATUTE DOES NOT APPLY TO THE TRANSFER OF AN INPATIENT WHO DID NOT PRESENT TO THE HOSPITAL'S EMERGENCY DEPARTMENT AND WHO WAS ADMITTED, STABILIZED AND TREATED FOR FIVE DAYS PRIOR TO HER TRANSFER TO ANOTHER HOSPITAL BASED ON MEDICAL NECESSITY.

As both the trial court and the Supreme Court of Virginia recognized, the legislative history of the patient dumping statute indicates that it was passed to eliminate the practice of some hospitals of refusing to treat persons in emergency conditions for economic reasons. App. B 15-16; App. A 8-10. In the instant case, plaintiff Connie Smith did not allege that she was refused treatment by Richmond Memorial Hospital or that she was transferred to MCV because she was uninsured or unable to pay hospital charges. In fact, plaintiffs' counsel conceded at the demurrer hearing that

Connie Smith was covered by health insurance when she was hospitalized at Richmond Memorial. Transcript of Demurrer Hearing at 44.

The patient dumping statute, 42 U.S.C. § 1395dd, requires that all Medicare participating hospitals with emergency departments provide an appropriate medical screening examination within the capability of the emergency department to any person who presents himself at the emergency room, regardless of ability to pay, in order to determine whether or not an emergency medical condition exists or to determine if the person is in active labor. § 1395dd(a). If it is determined that the person has an emergency medical condition or is in active labor, the hospital may not discharge or transfer the patient without providing stabilizing treatment within its

capabilities or without determining that a transfer would be in compliance with the requirements of the statute. § 1395dd(b). Such a patient may be transferred if a determination is made that "the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual's medical condition from effecting the transfer." § 1395dd(c)(1)(A)(ii). An individual who suffers personal harm as a direct result of a violation of a requirement of the patient dumping statute may obtain such damages as are allowed under state law. § 1395dd(d)(3)(A).

In order for subsections (b) and (c) of the Act to apply, a patient must present to the emergency room of a hospital in an emergency medical condition or in active

labor. As the court stated in Owens v. Nacogdoches County Hospital District, 741 F. Supp. 1269, 1271-72 (E.D. Tex. 1990):

> The Act was a response to a national epidemic of "dumping," the practice by hospitals of refusing emergency care to indigent patients outright or of transferring such patients, without regard to the necessity for stabilizing their condition, to other-- typically public-- hospitals....To address these problems, 42 U.S.C. § 1395dd requires that any hospital with an emergency room must provide a medical screening examination to any patient who appears complaining of an emergency medical condition. It further provides that such patients cannot be transferred to another facility in an unstable condition, and requires that such a transfer be "appropriate" (emphasis added).

See also Johnson v. University of Chicago Hosp., 774 F. Supp. 510, 513 (N.D. Ill. 1991); Deberry v. Sherman Hosp. Ass'n, 741 F. Supp. 1302, 1305 (N.D. Ill. 1990).

The Supreme Court of Virginia's reliance on Thornton v. Southwest Detroit Hospital, 895 F.2d 1131 (6th Cir. 1990), App. A 19-21, was misplaced. While it is true that in Thornton the patient was transferred after spending some twenty-one days in the hospital, she presented to the hospital emergency room with an emergency medical condition as envisioned by the Act. The Court in Thornton stated that "once a patient is found to suffer from an emergency medical condition in the emergency room, she can not be discharged until the condition is stabilized." 895 F.2d at 1134 (emphasis added). The court affirmed the district court's holding that COBRA was not applicable because the plaintiff was stabilized at the time of her release. Id. at 1135.

In contrast, the patient dumping statute does not apply to the instant case because Ms. Smith did not present to the emergency room of the Hospital. Nor has she alleged that when she came to the hospital that she was in an emergency condition or in active labor. Furthermore, she has admitted that during her five-day treatment at the Hospital she received stabilizing treatment. Given these facts, the trial court properly held that the plaintiffs had failed to state a cause of action under 42 U.S.C. § 1395dd and the Supreme Court of Virginia erred in holding otherwise.

While the plaintiffs made a conclusory allegation that Ms. Smith was transferred in violation of the statute, the facts pleaded made it obvious that the transfer occurred because "Richmond Memorial

Hospital does not have a Neonatal Intensive Care Unit and does not have the facilities to care for a premature infant, such as Taja Smith under the circumstances of the case." Motion for Judgment, ¶ 5. It was also alleged that Richmond Memorial Hospital "knew when it admitted Connie Smith to its hospital that it had inadequate facilities to care for a premature infant" and "knew or should have known that the patient Connie Smith should not be admitted to Richmond Memorial Hospital and/or should be transferred on a timely basis to another hospital with appropriate facilities." Id. ¶ 62.

Thus, Ms. Smith alleged not that the Hospital "dumped" her in violation of the Act, but that it should never have admitted her or having admitted her, that it should have treated her differently. Such claims

are not cognizable under the patient dumping statute, which addresses itself to a hospital's refusal to treat, not to misdiagnosis or inadequate treatment. See, e.g., Stewart v. Myrick, 731 F. Supp. 433 (D. Kan. 1990); Evitt v. University Heights Hosp., 727 F. Supp. 495, 497 (S.D. Ind. 1989); see also Petrovics v. Prince William Hosp. Corp., 764 F. Supp. 415, 417 (E.D. Va. 1991) (quoting Thornton v. Southwest Detroit Hosp., 895 F.2d 1131, 1133 (6th Cir. 1990) for the proposition that a patient dumping case is not analogous to a state medical malpractice claim because it creates liability for refusal to treat).

The treatment required to be given by a hospital is necessarily limited by "the staff and facilities available at the hospital." 42 U.S.C. § 1395dd(b)(1)(A). According to plaintiffs' own allegations,

a transfer to MCV, which unlike Richmond Memorial has a Neonatal Intensive Care Unit, was in the best interests of Connie Smith and her unborn child. Motion for Judgment, ¶5. The transfer was accomplished within twenty minutes. Id. ¶¶ 19 and 23. The dilation of Connie Smith's cervix was the same, one centimeter, before and after she was transferred, id. ¶¶ 11 and 30, and Taja Smith was not delivered at MCV for more than seven hours after her mother was admitted to MCV, id. ¶¶ 23 and 42. As the trial court stated: "At the time of the transfer, the condition of the mother and child required treatment beyond the resources available at defendant hospital....MCV had superior facilities to care for the condition of mother and child....Nothing indicates that the

transfer of a short distance was causally connected to the injury." App. B 18-19.

In holding that the motion for judgment stated a sufficient claim under the COBRA statute despite the absence of any allegation that Ms. Smith presented to the hospital's emergency department seeking a medical examination or treatment and was denied a screening examination or stabilizing treatment, the Virginia Supreme Court read the subsections of the statute in isolation, stating that "each subsection describes distinct patient circumstances requiring different treatment protocols." App. A-17. The court found nothing in the language of the statute which would limit subsections (b) and (c) to a patient who initially arrived at the emergency room and never received stabilizing treatment. Id. at 17-18. The court failed to apply

appropriate principles of statutory construction or to analyze the legislative history in order to discern the intent of Congress in passing the anti-dumping provisions. Id. at 18.

The Health Care Financing Administration ("HCFA") and the Office of the Inspector General of the Department of Health and Human Services are the agencies charged with the responsibility of administering and enforcing the anti-dumping provisions contained in § 1867 of the Social Security Act, 42 U.S.C. § 1395dd. In 1992, HCFA issued interpretative guidelines to state agencies that assist it in the investigation of complaints relating to the anti-dumping provisions of the statute. See App. E.

HCFA has instructed these agencies that the anti-dumping provisions do not

apply to all hospital transfers and that they do not apply to a patient beyond initial stabilization.

> The anti-dumping requirements continue to apply until the individual is properly examined, treated, stabilized and, if appropriate, either admitted to the hospital, discharged, or properly transferred, unless the individual or his/her representative refuses any of those services. This does not mean that the anti-dumping provisions apply to all hospital transfers. Once an individual's emergency medical condition is stabilized as defined under section 1867(e)(3) the hospital has met its obligations under this statute and it no longer is required to comply with the other anti-dumping documentation or transfer requirements (emphasis added).

App. E 6-7. Thus, HCFA construes COBRA "as applicable up to time of admission and until initial legal stabilization" and utilizes "patient safety standards for

subsequent transfer reviews." Frew Consulting Group, Ltd., "HCFA Issues COBRA Enforcement Policies," Critical Information Resource (March 1992).

The 1992 guidelines continue to reflect the same advice that HCFA has disseminated to providers all along concerning the applicability of subsections (b) and (c) of the Act to inpatient transfers. In preparing a special briefing for its member hospitals in 1990 on compliance with COBRA requirements, the American Hospital Association ("AHA") sought and received guidance from the Administrator of the Health Care Financing Administration, Gail Wilensky, see App. F-4; App. G; App. H, and communicated the following information to its members:

> Do the transfer protocols have to be observed for hospital inpatients?

> No. Taken together, these requirements describe a series of steps for the identification and treatment of individuals who come to a hospital's emergency department seeking care for an emergency medical condition. Many hospitals have questioned whether the requirements for transfer in this law would apply to hospital inpatients who develop emergency medical conditions and may need to be transferred to another facility. The logic of the law...suggests that it does not pertain to the transfer of hospital inpatients.

App. F 5-6.

In defining the scope of COBRA provisions, HCFA reads the requirements of subsections (a), (b) and (c) in context and applies the requirements of (b) and (c) regarding stabilizing treatment or appropriate transfer only to those individuals to whom subsection (a) refers, that is, individuals who have come to the emergency department of a hospital seeking medical treatment, who have been screened

and are determined to have an emergency medical condition. According to the HCFA policy statement, "all provisions of the anti-dumping statute, including the documentation and transfer requirements, are applicable once an individual with an emergency medical condition or a woman in labor presents him or herself and requests services at a Medicare participating hospital that has an emergency department" (emphasis added). App. E 5-6.

HCFA construes the subsections of the COBRA statute as interdependent rather than as isolated requirements. According to its enforcement guidelines, the six requirements contained in the statute apply only to hospitals that have an emergency department. App. E 9-17, 22-23. Subsection (a) provides that "[i]n the case of a hospital that has an emergency

department," an individual presenting to the emergency department seeking medical services must be given a screening examination in order to determine whether an emergency medical condition exists. 42 U.S.C.A. § 1395dd(a). This interpretation in HCFA's recently issued enforcement policies is consistent with the positions it has previously taken that the subsections of the COBRA statute must be read in conjunction with one another, not separately. See App. H and I.

HCFA's construction does not accord with the Virginia Supreme Court's emphasis in this case on the different phraseology in subsections (a), (b) and (c) -- "comes to the emergency department," "comes to a hospital," and "patient at a hospital," respectively -- and its conclusion that "each subsection describes distinct patient

circumstances requiring different treatment protocols." App. A-17. Presumably, the Virginia Supreme Court would read the subsection (a) requirement that the hospital have an emergency department out of subsections (b) and (c), just as it read out the requirement that the individual have presented to the emergency department.

HCFA's construction of the COBRA requirements is supported by the language of the statute itself. Section 1395dd (a) provides that when an individual comes to the emergency department of a hospital seeking medical services, the hospital must provide a medical screening examination "to determine whether an emergency medical condition exists." Subsection (b) provides that where "the hospital determines that the individual has an emergency medical condition, then the hospital must provide

stabilizing treatment or transfer the individual to another medical facility in accordance with subsection (c). The determination whether the individual has an emergency medical condition referred to in subsection (b) is the predicate to the duty in subsection (b) to provide stabilizing treatment or transfer and clearly flows from the requirements of subsection (a) that such a determination be made on behalf of individuals presenting to the emergency room. As the Virginia Supreme Court noted in this case, App. A-8, no such duty existed at common law.

Thus, subsection (b) is tied directly to subsection (a) and applies to a subset of the same class of individuals, that is, those individuals presenting to the emergency department of a hospital for medical examination or treatment who have

been determined to have an emergency medical condition. Subsection (b) specifically references subsection (c) regarding the manner in which such individuals may be transferred. Further evidence that subsection (c) applies to the same class of individuals defined in subsection (a) is found in § 1395dd(c)(1)(A)(ii) which refers to the availability of a physician "in the emergency department" as affecting who may sign the required certification for the transfer of an individual with an emergency medical condition which has not been stabilized. Unless subsection (c) refers to transfers from the emergency department this phrase has little if any meaning. Thus, subsections (a), (b) and (c) of the COBRA statute interrelate and describe the

hospital's continuing duty to a narrowly defined group of individuals.

Unlike the Virginia Supreme Court's construction of § 1395dd in this case, HCFA's interpretation of the law upholds a basic tenet of statutory construction -- that the statute be construed as a whole and that its individual sections or subsections be read in context. Erlenbaugh v. United States, 409 U.S. 239, 244 (1972); Crandon v. United States, 494 U.S. 152, 158, 164 (1990).

HCFA's interpretation of the law is supported by the legislative history of the anti-dumping provisions. The House Ways and Means Committee stated in its report that it was "greatly concerned about the increasing number of reports that hospital emergency rooms are refusing to accept or treat patients with emergency conditions if

the patient does not have medical insurance." H.R. Rep. No. 99-241, 99th Cong., 2nd Sess. 27, pt. I, at § 17, reprinted in 1986 U.S. Code Cong. & Admin. News 579, 605 (emphasis added). The Committee on the Judiciary also noted in its report that "[i]n recent years there has been a growing concern about the provision of adequate emergency room medical services to individuals who seek care, particularly as to the indigent and uninsured." H.R. Rep. No. 99-241, 99th Cong., 2nd Sess. 5, pt. III, reprinted in 1986 U.S.Code Cong. & Admin. News 726, 726 (emphasis added). The Committee recommended fines be imposed on a physician as well as a hospital "who fails to properly respond to the genuine medical needs of individuals who come to emergency rooms." Id. at 729 (emphasis added).

The COBRA amendment was described by two of its co-sponsors as attacking "the practice of dumping the sick and indigent from emergency rooms" and "addressing the critical problem of hospital emergency department dumping of the medically uninsured," 131 Cong. Rec. S13903, S13904 (October 23, 1985) (statements of Senators Durenberger and Heinz, respectively) (emphasis added). Senator Kennedy stated that the legislation was necessary, because while "[s]ome states have laws which ensure that no emergency patient is denied emergency care because of inability to pay ... 28 states have no such law. Federal legislation in this area is long overdue." 131 Cong. Rec. S13904 (October 23, 1985) (statement of Senator Kennedy). Congressional concern was clearly directed at the treatment, or lack thereof, of

indigent patients seeking emergency room services.

The Committee on the Judiciary defined the scope of the COBRA requirements as follows:

> This section requires a hospital which has a Medicare Provider Agreement and which operates an emergency department to provide an appropriate medical screening of any individual for whom a request for treatment is made. The purpose of this screening is to determine if an emergency medical condition exists or if the patient is in active labor. If the hospital determines that either condition exists, the hospital must provide further treatment to stabilize the individual or, if it determines to transfer the individual to another facility, it must properly complete this transfer.

H. R. Rep. No. 99-241, 99th Cong., 2nd Sess. 5, pt. III, reprinted in 1986 U.S.

Code of Cong. & Admin. News 726, 727. Likewise, the Committee on Ways and Means described the hospitals' obligations under the Act as follows: "[w]ithin their capacities, hospital emergency departments must provide appropriate treatment to stabilize patients who have emergency medical conditions or to provide treatment for patients in active labor, and provide for appropriate transfers." H.R. Rep. No. 99-241, 99th Cong., 2nd Sess. 4, pt. I, reprinted in 1986 U.S. Code of Cong. & Admin. News 579, 582 (emphasis added). No similar statement regarding necessary stabilizing treatment for inpatients was included. As Senator Dole stated, "[u]nder the provision of this amendment, a hospital is charged only with the responsibility of providing an adequate first response to a

medical crisis." 131 Cong. Rec. S13904 (statement of Senator Dole).

Thus, it is apparent that the problem identified and addressed by Congress by way of this legislation was the turning away of patients from the emergency departments of hospitals based primarily on their inability to pay. Furthermore, Congress was concerned that an adequate remedy did not otherwise exist because in many states there is no duty to treat emergency patients.

The Virginia Supreme Court expressed concern in the instant case that transferring an inpatient because his condition might result in substantial unreimbursed medical costs was equally reprehensible whether the patient arrived through the emergency room or not and whether he had been initially stabilized or

not. App. A 18-19. There is no evidence that Congress perceived that transfers outside of the emergency services area presented a problem, however.

As the Virginia Supreme Court acknowledged, a major impetus behind the enactment of the COBRA anti-dumping provisions was the fact that under the common law, hospitals had no duty to treat emergency patients. App. A-8. Thus, a federal cause of action was enacted where no common law action existed, at least in many states. With respect to the improper transfer of an inpatient, however, a common law cause of action does exist, because of the attachment of the physician-patient relationship, see, e.g., Lyons v. Grether, 218 Va. 630, 634, 239 S.E.2d 103, 106 (1977), and as a result of the implied contract between the patient and the

hospital, see, e.g., Stuart Circle Hospital v. Curry, 173 Va. 136, 146-47, 3 S.E.2d 153, 157 (1939). Having assumed the duty to treat, the physician and the hospital are required to do so in a non-negligent manner.

HCFA has construed the COBRA requirements as evidenced in its recently issued guidelines to state agencies, App. E, and in earlier letters responding to inquiry from the American Hospital Association and from hospital counsel, App. H and I, to mean that there is no continuing COBRA duty after initial stabilization and that subsections (b) and (c) apply only to those persons presenting themselves to a hospital's emergency department under subsection (a). This construction accords not only with the

letter of the law, but with Congress' legislative intent, as outlined above.

The construction of a statute by the administrative agency that is charged with the responsibility of enforcing it is entitled to great deference. See Chevron U.S.A. Inc. v. Natural Resources Defense Council, 467 U.S. 837, 842-43 (1984); see also C. Koch, Administrative Law and Practice § 3.53 (1985). It is incongruous for private litigants in the Commonwealth of Virginia to be proceeding under a construction of the COBRA statute rendered by the state supreme court which directly conflicts with the construction of the statute utilized by state agencies in Virginia assisting HCFA in investigating COBRA complaints.

The Court should grant the Hospital's petition for certiorari on this issue

because the Virginia Supreme Court's interpretation of COBRA conflicts with the language of the statute, clearly expressed Congressional intent and the interpretation of the federal regulatory agency charged with administering the law.

## II. THE NOTICE OF CLAIM AND PANEL REQUIREMENTS OF VIRGINIA'S MEDICAL MALPRACTICE ACT ARE NOT PREEMPTED BECAUSE THEY DO NOT DIRECTLY CONFLICT WITH ANY REQUIREMENT OF COBRA

Section 1395dd(f) provides that the COBRA provisions do not "preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section." The Supreme Court of Virginia held that the notice of claim and review

panel provisions[4] of the Virginia Medical Malpractice Act, Va. Code Ann. § 8.01-581.2, are not applicable to a COBRA claim because they would directly conflict with the two-year statute of limitations prescribed in 42 U.S.C. § 1395dd(d)(3)(C). App. A-34.

As the court noted, the notice of claim provisions prohibit a plaintiff from filing suit until 90 days after written notice of the claim is given to the health care provider, and, if the provider

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[4] Unless preempted by COBRA, the notice of claim provision would apply to the instant case, because it applies to all malpractice actions, § 8.01-581.2, and "malpractice" is defined as "any tort based on health care or professional services rendered, or which should have been rendered, by a health care provider," Va. Code Ann. § 8.01-581.1. In Glisson v. Loxley, 235 Va. 62, 67, 366 S.E.2d 68, 71 (1988), the Virginia Supreme Court defined "tort," in the notice of claim context, as "the violation of some duty owing to the plaintiff imposed by the general law or otherwise."

requests that the issue be reviewed by a malpractice review panel, until the panel completes its review. App. A-32. Section 8.01-581.9 of the Medical Malpractice Act, however, tolls "the applicable statute of limitations for a period of 120 days from the date such notice is given, or for 60 days following the date of issuance of any opinion by the medical review panel" (emphasis added). The court stated that this tolling provision can toll only a state statute of limitations, App. A 32, 33-34. The court reasoned that the notice of claim provisions directly conflicted with the two-year COBRA statute of limitations because compliance with the notice provisions of the Virginia statute could result in the inability of a litigant to file a claim within the limitations period. App. A-34.

There is no direct conflict which preempts either the notice of claim[5] or the tolling provision. Burrows v. Turner Memorial Hospital, 762 F. Supp. 840, 843 (W.D. Ark. 1991), the sole authority relied upon by the Virginia Supreme Court for the proposition that a state tolling statute can not toll a federally prescribed statute of limitations, is inapposite, because Burrows and the cases cited therein address whether a state statute will toll a federal statute of limitations for a federal cause

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[5] See Draper v. Chiapuzio, 755 F. Supp. 331 (D. Ore. 1991) (holding that Oregon's notice of wrongful death claim against public body applies to patient dumping claim); see also Wilson v. Atlanticare Medical Center, 868 F.2d 34, 35 (1st Cir. 1989) (While the court did not reach the question whether state malpractice panel referral and notice requirements apply to a patient dumping action, it observed that "hospitals...need screening protection against frivolous claims as much under the federal statute as they do for other malpractice charges.")

of action filed in federal court. Where a federally created cause of action is filed in state court, state procedural rules regarding commencement and tolling apply, even where the statute of limitations is federally prescribed. See 2 J. Moore, J. Lucas, H. Fink, & C. Thompson, Moore's Federal Practice ¶ 3.09[2]n.15 (2d ed. 1991).

Inasmuch as the Virginia Supreme Court has wrongly decided that there is a direct conflict between COBRA and Virginia's Medical Malpractice Act notice of claim provisions, thereby preempting the State law and depriving Virginia hospitals of an important right, the Hospital's petition for certiorari on this issue should be granted.

## CONCLUSION

For the reasons stated above, the Hospital's petition for certiorari should be granted.

Respectfully submitted,

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September 3, 1992

## APPENDIX A

Present: Carrico, C.J., Compton, Stephenson, Whiting, Lacy, and Kennan, JJ., and Cochran, Retired Justice

OPINION BY JUSTICE
ELIZABETH B. LACY
April 17, 1992

TAJA SMITH, AN INFANT, ETC., ET AL.

v. Record No. 910585

RICHMOND MEMORIAL HOSPITAL

FROM THE CIRCUIT COURT OF THE
CITY OF RICHMOND
Robert L. Harris, Sr., Judge

In this case we consider whether the trial court properly sustained a demurrer without leave to amend on the ground that the motion for judgment failed to state a cause of action under the Emergency Medical Treatment and Women in Active Labor provisions of the Consolidated

Omnibus Budget Reconciliation Act (COBRA or the Act), 42 U.S.C. § 1395dd (1988).

The circumstances of this case involve the medical treatment of a pregnant woman who subsequently gave birth to a child. We recite the facts as set out in the pleadings, taken as true for the purposes of reviewing the trial court's action on the demurrer. Bowman v. State Bank of Keysville, 229 Va. 534, 536, 331 S.E.2d 797, 798 (1985).

Connie Elizabeth Smith was admitted to Richmond Memorial Hospital (the Hospital) as a patient on July 18, 1988. Ms. Smith was approximately 33 weeks pregnant and had premature rupture of the uterine membranes. Ms. Smith remained at the Hospital until July 23, 1988.

During the afternoon of July 22, 1988, Ms. Smith complained of abdominal cramping and vaginal leakage. The discharge had turned to a greenish yellow color. In the afternoon and again at 10:00 p.m. she was given Nembutal, a hypnotic drug. By 10:00 p.m., Ms. Smith was complaining of irregular abdominal pain and contractions. By 10:30 p.m., her contractions were timed at five minute intervals. At 11:45 p.m., she was taken to the labor and delivery facilities of the Hospital. The vaginal discharge was now dark green in color. By midnight, the opening to the patient's uterus had dilated one centimeter, she had cold chills, and her temperature had dropped to 95.3 degrees Fahrenheit.

At 1:00 a.m., the Hospital called a physician, who ordered that Ms. Smith be transferred to the Medical College of Virginia Hospital (MCV). The physician was not Ms. Smith's regular attending physician, and he gave the verbal transfer order without examining her. Following the transfer order, a nurse began trying to locate an ambulance service to transfer Ms. Smith to MCV. Two services refused, and one was not obtained until the Richmond Memorial administrator agreed that the cost of the transfer could be billed to MCV. Connie Smith was taken from the Hospital at 2:10 a.m. and was admitted to MCV at approximately 2:30 a.m. on July 23, 1988.

A medical resident at MCV assessed Ms. Smith's condition to be "(1)

prolonged premature rupture of the membranes, (2) pre-term labor at 34 weeks, (3) the Chorioamnionitis should be ruled out, and (4) that there was questionable meconium discharge." At 3:00 a.m., Ms. Smith signed a consent for a caesarean delivery, if necessary. Her contractions were one to five minutes apart at 4:20 a.m. She was taken "emergently" to the delivery room where the child, Taja Smith, was delivered by caesarean operation at approximately 9:48 a.m. Both mother and child suffered substantial injuries. Taja has cerebral palsy and is severely brain damaged.

Ms. Smith sued Richmond Memorial Hospital in her individual capacity and on behalf of her daughter Taja (collectively Smith), claiming a

violation of COBRA and seeking damages. The Hospital demurred on three grounds: (1) the claims are "actually those alleging medical malpractice" and, therefore, the circumstances alleged cannot support a claim against the Hospital under COBRA; (2) no actionable claim under COBRA was stated because Smith did not allege that indigency was the motivating reason for the transfer from Richmond Memorial Hospital to MCV; and (3) no notice of claim as required by Code § 8.01-581.2 was given.

The trial court first determined that Code § 8.01-581.2 notice of claim provisions were inapplicable to claims based on a COBRA violation. Next, stating that the "crux of the issue presented by plaintiff is that she

remained at Richmond Memorial without adequate care," the trial court held that COBRA does not cover "emergency conditions arising from medical neglect during a stay in a hospital." Accordingly, the trial court agreed with the Hospital's argument that Smith's claim was actually one for medical malpractice and held that a cause of action under COBRA was not sufficiently pled. The trial court sustained the demurrer without leave to amend.

We awarded Smith an appeal. We also granted a review of the Hospital's assignment of cross-error regarding the applicability of the notice of claim

provisions of Code § 8.01-581.2 to claims filed under COBRA.[1]

I.

Congress enacted COBRA in 1986 in response to the growing number of instances in which hospitals were refusing to treat individuals with emergency medical conditions, a practice generally referred to as "patient dumping." Under the common law, private hospitals have no duty to accept or to provide treatment for patients. While private hospitals traditionally did treat people in emergency situations, they

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[1]Although the Hospital argues on brief that an allegation of economic motivation for the transfer was an essential pleading requirement in this case, the trial court did not rule on this argument, and that issue is not before us.

generally were not fully compensated, or were not compensated at all, for treatment of indigent patients. With growing competition among hospitals, shifting this cost to paying patients became more difficult. As the hospitals' economic losses increased, the instances of patient dumping also increased. To counteract patient dumping and the resultant hardship and injury, COBRA established specific standards for the evaluation, treatment, and transfer of patients. Abercrombie v. Osteopathic Hosp. Founders Ass'n, 950 F.2d 676, 680 (10th Cir. 1991); Gatewood v. Washington Healthcare Corp., 933 F.2d 1037, 1039 (D.C. Cir. 1991); Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266, 268 (6th Cir. 1990); Andrew Jay McClurg,

Your Money or Your Life: Interpreting the Federal Act Against Patient Dumping, 24 Wake Forest L. Rev. 173, 197-99 (1989); Karen I. Treiger, Note, Preventing Patient Dumping: Sharpening the Cobra's Fangs, 61 N.Y.U. L. Rev. 1186, 1187-88 (1986).

II.

The Hospital argues that Smith did not plead a claim under COBRA for two reasons. First, asserting that coming to an emergency room in an emergency medical condition or in active labor is a prerequisite to the application of the treatment and transfer provisions of subsections (b) and (c) of the Act, the Hospital argues that Smith's claim fails because she did not plead that she came

to the emergency room in such a condition. Furthermore, the Hospital asserts that Smith's admission that her condition had been stabilized prior to the events giving rise to her transfer to MCV absolves the Hospital from liability under COBRA. Second, the Hospital argues that Smith's claim is one for misdiagnosis or improper treatment, and, therefore, that it is not cognizable under COBRA. In response, Smith contends that, under the Act's language, a patient need not be transferred from an emergency room to establish a COBRA cause of action, and that a hospital cannot escape COBRA liability by "initially stabilizing a patient, allowing the patient to again become unstable, and then transferring the patient."

Although framed in terms of the sufficiency of the pleading, the crux of the issue in this case is one of statutory interpretation: (1) whether COBRA's treatment and transfer requirements are limited solely to an emergency medical condition or active labor which has not been stabilized and which occurs in conjunction with initial admission to an emergency department; or (2) whether those requirements also apply when an emergency medical condition or active labor commences after the admission and initial stabilization of the patient's condition.

To resolve the parties' conflicting interpretations, we begin with an examination of the Act itself. At the

time of the alleged violation, 42 U.S.C. § 1395dd stated in relevant part:

> (a) **Medical screening requirement**
>
> In the case of a hospital that has a hospital emergency department, <u>if any individual</u> (whether or not eligible for benefits under this subchapter) <u>comes to the emergency department</u> and a request is made. . . for examination or treatment . . . the hospital must provide for an appropriate medical screening examination . . . to determine whether or not an emergency medical condition . . . exists or to determine if

the individual is in active labor . . . .

(b) **Necessary stabilizing treatment for emergency medical conditions and active labor**

(1) In general

If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition or is in active labor, the hospital must provide either -

(A) . . . such further medical examination and such treatment as may be required to stabilize the medical condition or . . . provide for treatment of the labor, or

(B) for transfer of the individual to another medical facility in accordance with subsection (c) of this section.

. . .

(c) **Restricting transfers until patient stabilized**

(1) Rule

If a patient at a hospital has an emergency medical condition which has not been stabilized . . . or is in active labor, the hospital

may not transfer the patient unless -

> (A)(i) the patient . . . requests that the transfer be effected, or
>
> (ii) a physician . . . or other qualified medical personnel when a physician is not readily available in the emergency department, has signed a certification that . . . the medical benefits reasonably expected from the . . . [transfer] outweigh the increased risks to the individual's medical condition from effectuating the transfer . . . .

(Emphasis added.)

The language used in each subsection describes distinct patient circumstances requiring different treatment protocols. If an individual "comes to the emergency department," the hospital must provide an appropriate medical screening examination. Id. at § 1395dd(a). If an individual "comes to a hospital" and the hospital determines that an emergency medical condition or active labor exists, the hospital must stabilize the condition or transfer the person. Id. § 1395dd(b). If a "patient at a hospital" has an emergency condition or is in active labor, the hospital may transfer that patient only under certain conditions. Id. § 1395dd(c).

The statutory language clearly requires a patient to be in an emergency

medical condition or to be in active labor before the provisions of subsections (b) and (c) apply. But we find nothing in the language of the Act which limits application of these subsections solely to a patient who initially arrives at the emergency room and who has not been stabilized, as the Hospital argues here. When the words of the statute are plan and unambiguous we need not resort to rules of statutory construction or legislative history. Marsh v. City of Richmond, 234 Va. 4, 11, 360 S.E.2d 163, 167 (1987).

This interpretation of the Act is consistent with the legislation's purpose. Patient dumping is not limited to a refusal to provide emergency room treatment. See Thompson v. St. Anne's

Hosp. , 716 F.Supp. 8 (N.D. Ill. 1989). It occurs, and is equally reprehensible, at any time a hospital determines that a patient's condition may result in substantial medical costs and the hospital transfers the patient because it fears it will not be paid for those expenses. Dumping a patient in this manner is neither related to, nor dependent upon, the patient arriving through the emergency room and never being stabilized.

We are unaware of any case which has addressed this specific issue. The rationale of two cases considering the construction and purpose of the Act, however, is consistent with our interpretation of the statutory language. In Thornton v. Southwest Detroit Hosp.,

895 F.2d 1131 (6th Cir. 1990), a patient was taken to a hospital emergency room and then admitted to the intensive care unit where she was treated for ten days. She was later transferred to regular in-patient care where she was treated for another 11 days and was then discharged. After examining the use of the words "emergency room" and "hospital" in subsections (a), (b), and (c) of the Act, the court rejected the Hospital's argument that the Act's requirement of care for a patient did not extend beyond the emergency room to the intensive care and in-patient areas. The court reasoned that COBRA was intended to "insure that patients with medical emergencies would receive emergency care . . . [which] does not . . . stop when a patient is wheeled

from the emergency room into the main hospital." Id. at 1135.

The rationale of Thornton was cited and utilized in Loss v. Song, No. 89C 6952, 1990 WL 159612 (N.D. Ill. 1990) (mem.). There, the hospital argued that a child with an emergency medical condition who was born at the hospital was precluded from bringing an action under COBRA because the child could not plead that he was admitted to or through the emergency room. The Loss court allowed the child's case to proceed, holding that allegations that "from the moment he was born in the defendant hospital, [he] suffered from a severe congenital cardiac disease" were sufficient to state a claim under COBRA. Id. at *4. In both of these cases, the

court examined the statutory language and found that it required the treatment of medical emergency conditions, irrespective of the manner in which the patient arrived at the institution or where within the hospital the treatment was provided.

The Hospital relies on specific language in three cases to support its argument that a plaintiff must allege arrival at an emergency room to state a cause of action under COBRA. The precedential value of those statements to this case is diminished, however, in light of the specific facts of the cases. In Johnson v. University of Chicago Hosp., 774 F.Supp. 510 (N.D. Ill. 1991), the patient was never taken to the emergency room of the defendant hospital,

nor was she ever even present in the hospital. The issue in Deberry v. Sherman Hosp. Ass'n, 741 F.Supp. 1302 (N.D. Ill. 1990), was whether stating a claim under COBRA required pleading that the hospital's failure to treat was based on the patient's inability to pay.[2] Statements regarding the need to plead an arrival or physical presence at an emergency room, unaccompanied by any issues or facts analogous or similar to those in the instant case, are neither determinative nor persuasive.

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[2]Loss, supra, and Deberry were both decided in the Federal District Court for the Northern District of Illinois. In Loss, the court acknowledged its prior statement in Deberry that a "would-be COBRA plaintiff" must plead presentation to the emergency room, but did not consider that statement as applying in all COBRA cases. Loss, 1990 WL 159612 at *3.

Finally, the Hospital cites the following passage from Owens v. Nacogdoches County Hosp. Dist., 741 F.Supp. 1269 (E.D. Tex. 1990), as dispositive of the issue:

> To address these problems, 42 U.S.C. § 1395dd requires that any hospital with an emergency room must provide a medical screening examination to any patient who appears complaining of an emergency medical condition. It further provides that such patients cannot be transferred to another facility in an unstable condition, and requires that such a transfer be "appropriate."

(Emphasis added). Id. at 1272. This passage appears in the court's general discussion of the Act entitled "I. Background-42 U.S.C. § 1395dd." It is neither the result of an analysis of the specific provisions of the Act nor part of any holding made by the court in conjunction with the issues in the case. Reliance on a single word contained in an abstract discussion of the general nature is misplaced, and provides no support for the Hospital's position in this case.

Although the legislative history of COBRA indicates Congressional concern with denial of treatment and inappropriate transfers of indigent persons who come to the emergency rooms of hospitals, the plain language Congress chose does not limit the Act to those

circumstances. Many courts called on to interpret the language of the Act have reached similar conclusions regarding the breadth of coverage the statutory language provides, in contrast to the more focused scope reflected in the legislative history of the Act. See e.g., Brooker v. Desert Hosp. Corp., 947 F.2d 412, 414-15 (9th Cir. 1991); Gatewood, 933 F.2d at 1040; Lee by Wetzel v. Alleghany Regional Hosp. Corp., 778 F.Supp. 900, 902 (W.D. Va. 1991); Delaney v. Cade, 756 F.Supp. 1476, 1485-86 (D. Kan. 1991). As stated by the court in Cleland v. Bronson Health Care Group, Inc.:

> The words of the statute . . . are quite plain, and interpreting them as such does not lead to an absurd

> result. It leads to a result considerably broader than one might think Congress should have intended, or perhaps than any or all individual members of Congress were cognizant of. However, it is not our place to rewrite statutes to conform with our notions of efficacy or rationality. That is the job of Congress. . . . Here, the result we reach in no way vitiates or is contrary to Congress's indicated concern in passing the legislation. It may go further than what Congress contemplated, but that is not a reason to distort or excise the words that Congress wrote.

917 F.2d at 270.

We agree with this rationale, and it is equally applicable in this case. The words of the statute are plain, and our interpretation of those words does not subvert the purpose of the legislation or lead to an absurd result. Accordingly, we hold that the transfer provisions of § 1395dd(c) are applicable to situations in which a patient in a hospital has an emergency medical condition or is in active labor as defined by the Act.

Turning to the sufficiency of the pleadings, Smith alleged, inter alia, that just prior to transfer she was suffering from pains and abdominal cramping, had discolored vaginal discharge, experienced a temperature drop, and had frequent uterine contractions, and had begun to dilate.

The pleadings also state that no certificate such as is required by § 1395dd(c)(1)(A)(ii) was executed in conjunction with Smith's transfer to MCV. These facts, along with the allegations that Smith was in active labor and had an emergency medical condition at the time of the transfer and that the Hospital did not comply with the requirements for transfer, are sufficient to state a claim under COBRA.[3]

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[3]In light of this holding we do not address the Hospital's second argument, that the claim is actually one of misdiagnosis or improper treatment. The Hospital admits that a medical malpractice and COBRA claim can exist simultaneously and we have held that a COBRA claim has been plead. Whether the COBRA claim here is in reality only a traditional malpractice claim, as the Hospital argues, is an issue of fact, not pleading, and might be the subject of a motion for summary judgment as in Stewart v. Myrick, 731 F.Supp. 433 (D. Kan. 1990), and Evitt v. University Heights Hosp., 727 F.Supp.

III.

Because the action of the trial court in sustaining the Hospital's demurrer will be reversed and the case remanded for the reasons stated above, we must consider the Hospital's assignment of cross-error. The Hospital asserts that the trial court erred in holding that the notice of claim provisions of Va. Code § 8.01-581.2 are inapplicable to claims under COBRA. We disagree with the Hospital.

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495 (S.D. Ind. 1989). See also Anadumakav v. Edgewater Operating Co., No. 91 C 5374, 1992 WL 6726 (N.D. Ill. 1992); Coleman v. McCurtain Memorial Medical Management, Inc., 771 F.Supp. 343 (E.D. Okla. 1991); Lee, 778 F.Supp. at 903. Compare Deberry v. Sherman Hosp. Ass'n, 741 F.Supp. 1302 (N.D. Ill. 1990) with Deberry v. Sherman Hosp. Ass'n, 769 F.Supp. 1030 (N.D. Ill. 1991).

Subsection (f) of COBRA provides that:

> The provisions of this section do not preempt any state or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

The Hospital argues that the state notice of claim provisions do not conflict with COBRA. In support of this position, the Hospital cites Draper v. Chiapuzio, 755 F.Supp. 331, 333 (D.Or. 1991), which held that the Oregon requirement that notice of a wrongful death claim against a public body be filed within one year after the death did not conflict with COBRA. The Oregon statute, however,

involved only a simple notice of claim, which is a significant distinction.[4]

The Virginia notice provisions not only require a plaintiff to provide written notice of the claim to the health care provider, they also absolutely prohibit the filing of a medical malpractice claim against the health care provider until 90 days after such notification and, if the health care provider chooses to have the issue reviewed by a malpractice review panel, the suit cannot be filed until the panel completes its review. Code § 8.01-581.2(A). The state statute of limitations is tolled during this period.

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[4]We also note that the complaint in Draper was not limited to a cause of action under COBRA as was the complaint here, but also included a cause of action for common law negligence.

It is this aspect of the notice of claim provision which is in direct conflict with the provisions of COBRA.

Subsection (d)(3)(C) of COBRA establishes a two-year statute of limitations for the filing of claims under the Act. COBRA establishes a separate federal cause of action, cognizable in federal and state courts, independent of any additional or pendant state claims. Sorrells v. Babcock, 733 F.Supp. 1189 (N.D. Ill. 1990); Reid v. Indianapolis Osteopathic Medical Hosp. Inc., 709 F.Supp. 853 (S.D. Ind. 1989); Bryant v. Riddle Memorial Hospital, 689 F.Supp. 490 (E.D. Penn. 1988). The tolling provisions of the state statute cannot act to toll the running of the statute of limitations established in

federal legislation which created a federal right of action. Burrows v. Turner Memorial Hosp., Inc., 762 F.Supp. 840, 843 (W.D. Ark. 1991).

Unlike the Oregon requirement, the Virginia notice of claim provision is not restricted to a mere notice. Compliance with the notice provisions of the Virginia statute could result in the inability of a litigant to file a claim within the COBRA two-year statute of limitations period. Consequently, we hold that the trial court correctly ruled that the notice of claim provisions of Code § 8.01-581.2 conflict with the requirements of COBRA and, therefore, are inapplicable to COBRA causes of action.

For the reasons discussed above, the judgment of the trial court will be

affirmed in part and reversed in part, and the case remanded for further proceedings.

Affirmed in part,
reversed in part, and remanded.

## APPENDIX B

*Circuit Court*
of the
*City of Richmond*
*John Marshall Courts Building*

March 8, 1991

Robert L. Harris, Sr.
Judge

800 East Marshall Street
Richmond, Virginia 23219

Edward W. Taylor, Esq.
Taylor & Schockemoehl, P.C.
601 North Courthouse Road
Richmond, VA 23236

Richard Tyler McGrath, Esq.
Crews & Hancock
Suite 1015, Seven Hundred Building
Post Office Box 1474
Richmond, VA 23212-1474

Gentlemen:

Re: Taja Smith, an infant who sues by and through her next friend and mother, Connie Elizabeth Smith and Connie Elizabeth Smith Individually v. Richmond Memorial Hospital
Case No. LS 2441-2

This matter comes before the court on Defendant's demurrer. The demurrer is sustained without leave to amend.

"A demurrer admits the truth of all material facts that are properly pleaded. According to this rule, the facts admitted are those expressly alleged, those which are impliedly alleged, and those which may be fairly and justly inferred from the facts alleged." Elliott v. Shore Stop, Inc., 238 Va. 237, 384 S.E.2d 752 (1989). Cognizant of these principles, the facts presented are as follows.

On July 18, 1988 plaintiff Connie Smith, a pregnant woman, hereinafter referred to as "mother" became a patient at defendant Richmond Memorial Hospital, hereinafter referred to as "Richmond Memorial." At the time of admission, mother had premature rupture of the membranes, with only a small amount of

fluid remaining. The gestational age of Taja Smith, hereinafter referred to as "child", was estimated to be approximately 32.5 to 33 weeks.

Mother remained at Richmond Memorial Hospital from July 18 until July 23 at which time she was transferred to Medical College of Virginia Hospital, hereinafter referred to as "MCV". During her stay at Richmond Memorial her condition deteriorated and she continued to leak fluid. By 4:30 p.m. on July 22 the leakage from her vagina had turned greenish yellow in color, and she experienced abdominal cramping. By 11:45 p.m. that night the discharge was dark green in color and she experienced frequent contractions. At midnight on July 22 she was dilated one centimeter.

Several hours later she suffered cold chills and a temperature drop to 95.3° F.

At 2:10 a.m. on July 23 mother was transferred by ambulance to MCV. Shortly after admission to MCV, her temperature elevated to 100.2° F. A cesarean operation was performed on the mother and delivery of the child occurred at 9:48 a.m. on July 23. The estimated gestational age at birth was determined to be 36 weeks.

The child was placed in the neonatal intensive care unit of MCV. She was resuscitated at birth, but several hours later experienced seizures. MCV continued to treat the child until her discharge on September 6. Her discharge diagnosis was:

1. Asphyxia neonatorum;

2. Grade Three ventricular hemorrhage with subsequent Hydrocephalus;

3. E-Coli Sepsis;

4. Seizure disorder; and

5. Hyperbilirubinemia.

Both mother and child suffered substantial injuries. The child has cerebral palsy. Because of her severe brain damage she is unable to speak, walk, stand, feed herself or control her elimination. Subsequent medical treatment was administered to the child for her personal injuries. After delivery, the mother experienced additional complications. Her womb had to be reopened due to infection and she developed bowel obstruction.

Plaintiff filed a motion for judgment on July 17, 1990 alleging violation of the Emergency Medical Treatment and Women in Active Labor provision of the Consolidated Omnibus Budget Reconciliation Act (COBRA), 42 U.S.C. § 1395dd. This statute is often referred to as the "patient dumping law." The motion for judgment contained no other counts.

Under common law, a hospital had no affirmative duty to treat a patient. Hospitals were free to refuse treatment or transfer to another institution those patients that were either unable to pay or were anticipated to be financially unprofitable. That practice was commonly referred to as "patient dumping." In the mid 1980's public scrutiny was focused on

several highly publicized cases of hospitals dumping patients in dire need of emergency care. In the resulting public outcry for the elimination of this practice, the patient dumping law was passed by Congress.

Compliance with the Act has become a conditional prerequisite of Medicare participation. The provisions of the statute include screening any individual presented to the emergency department, and furnishing treatment until the patient is stabilized or delivering the child of a woman in active labor. Additionally, the Act provides for the transfer of a patient to another institution.

The statute includes enforcement mechanisms to ensure compliance. The hospital's provider contract may be terminated or suspended by the Secretary of the Department of Human Services. Additionally, civil penalties may be imposed for violation. Finally, the statute authorizes a private cause of action against the transferring hospital.

Section 1395dd (d)(3)(A) of the Act states:

> Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of

the State in which the hospital is located, and such equitable relief as is appropriate.

The forum available to the private action is not stated in the Act. Therefore, ambiguity exists on the face of the statute. Brown v. Lukhard, 229 Va. 316, 330 S.E.2d 84 (1985). When ambiguity exists in statutory language, legislative history and extrinsic facts may be reviewed to determine the meaning. Va. Dept. of Labor & Industry v. Westmoreland Coal, 233 Va. 97, 353 S.E.2d 758 (1987).

The Committee on Ways and Means which reviewed H.R. 3128 stated that a private enforcement action may be brought "in an appropriate state or Federal district court . . . ." H.R. Rep. No. 241(I) 99th Cong., 1st Sess. 28,

reprinted in 1986 U.S. Code Cong. & Admin. News 606. The Committee on the Judiciary subsequently reviewed the Committee on Ways and Means' report, reaching the same conclusion that state and federal courts should have concurrent jurisdiction. H.R. Rep. No. 241 (III), 99th Cong., 1st Sess., 7, reprinted in 1986 U.S. Code Cong. & Admin. News 729.

Legislative history was cited in Bryant v. Riddle Memorial Hosp., 689 F. Supp. 490 (E.D. Pa. 1988) in support of the conclusion that a private action could be initiated in federal court. The legislative history similarly compels the conclusion that there is concurrent jurisdiction in state court.

Jurisdiction being proper in this court, we shall review the substantive

issues presented. Defendant demurs on three grounds. Initially we shall consider whether plaintiffs were required to give notice of their claim pursuant to Va. Code § 8.01-581.2 prior to initiating a COBRA action.

Pursuant to Va. Code § 8.01-581.2(A) a plaintiff must first serve a Notice of Claim upon the allegedly negligent health care provider before bringing a medical malpractice action. Within 60 days, the health care provider may request a review of the claim by an appointed medical malpractice review panel. If the health care provider requests a panel, suit may not be filed until completion of the review.

Plaintiffs have never mailed a Notice of Claim to defendant and have not

coupled a state medical malpractice claim with the COBRA count in the action before the court. The patient dumping count is the sole count in the Motion for Judgment. Defendant has demurred to the action based on the failure to file notice of claim.

Whether the procedural requirements of state medical malpractice claims are applicable to the COBRA claim has been considered with differing results by several federal courts. Draper v. Chiapuzio, No. 90-7909-FR (D. Or. Jan. 28, 1991) (available on Westlaw, Allfeds library, 1991 WL 10027 (D.Or.)); Toliver v. Culpeper Memorial Hospital, Inc., Civil Action No. 90-0501-A, memorandum opinion (Aug. 30, 1990); Reid v. Indianopolis Osteopathic Medical

Hospital, 709 F. Supp. 853 (S.D. Ind. 1989).

In Toliver, supra, the court determined that application of the Virginia procedural limitations would contravene the intent of the patient dumping law. "Any conclusions by a state review panel convened to explore the possibilities of negligence by a local health care provider are logically irrelevant to the federal equation and directly at odds with its spirit. Congress could not have intended such an absurd result." Id. at 7. The court conceded that "the Virginia statute depriving its courts the jurisdiction to hear medical malpractice claims while a review panel is convened to make a preliminary inquiry will not be

applicable to the plaintiffs' federal COBRA claims." Id. at 8.

The issue presented in the case at hand is analogous to that presented in Toliver. In Toliver the court determined that the state statute depriving jurisdiction while a panel was convened was inapplicable to the federal patient dumping cause of action. Similarly, I find that the provision of § 8.01-581.2(A) which provides "No action may be brought for malpractice against a health care provider unless the claimant notifies the health care provider in writing by registered or certified mail prior to commencing the action" is likewise inapplicable. All state imposed limitations of § 8.01-581.2 are inapplicable to this federal cause of

action, regardless of whether the patient dumping claim is brought in state or federal court.

Defendant's demurrer alleges that plaintiff's claim is actually one for medical malpractice. I find this argument compelling and sustain the demurrer on this ground.

The legislative history of the Act indicates that it was passed to eliminate the practice of some hospitals of rejecting persons in emergency conditions. The patient dumping law does not generally preempt state medical malpractice law. Evitt v. University Heights Hospital, 727 F. Supp. 495, 497 (S.D. Ind. 1989).

The plaintiff's interpretation reaches beyond the purpose of the

statute, which is specifically directed toward preventing prospective patients from being turned away for economic reasons.

Underlying plaintiff's reading of the screening provision is her implicit complaint that she was misdiagnosed. Following her reasoning, if [her physician] had suspected she was having a heart attack, he would have ordered a 12-lead EKG, which would have confirmed his suspicions and led to the plaintiff's admission and further treatment. This complaint, rather than focusing on the "dumping" problem, begins by attacking the doctor's provisional

> diagnosis. Claims regarding diagnosis and treatment lie in the area of medical malpractice, an area traditionally regulated by state law. To adjudicate these issues under the anti-dumping provision would lead to federal preemption not contemplated under this Act.

Evitt, supra. at 497 (citations omitted).

In Evitt, Id. and Stewart v. Myrick, 731 F. Supp. 433 (D.Kan. 1990), the court concluded that the patient dumping law was not intended to guarantee proper emergency room diagnosis and treatment. I concur that the Act was never intended for this purpose.

Under the facts pleaded in the case at hand, mother was admitted to Richmond

Memorial on July 18 and was permitted to stay in the hospital with little treatment, for five days. Unfortunately, she was kept at the hospital with improper care. At the time of transfer, the condition of mother and child required treatment beyond the resources available at defendant hospital.

The Act does not insure that emergency conditions arising from medical neglect during a stay in a hospital would be enveloped by the Act. Plaintiff's motion for judgment contains allegations of standard negligence. The crux of the issue presented by plaintiff is that she remained at Richmond Memorial without adequate care. When Richmond Memorial realized the seriousness of mother's condition, they transferred her to MCV.

MCV had superior facilities to care for the condition of mother and child. Regretfully, the treatment and transfer to MCV was delayed, causing damage to plaintiffs. Nothing indicates that the transfer of a short distance was casually connected to the injury.

Under the facts presented, a cause of action for patient dumping is not sufficiently pleaded. Demurrer is sustained without leave to amend. However, once there has been compliance with the necessary procedures, this court will entertain a medical malpractice claim among these parties, provided the statute of limitations has not run.

Very truly yours,

ROBERT L. HARRIS, SR.

RLH/vgt

VIRGINIA:

IN THE CIRCUIT COURT OF THE CITY OF RICHMOND, JOHN MARSHALL COURTS BUILDING

THE 8TH DAY OF MARCH 1991

TAJA SMITH, an infant who sues by her friend and mother, Connie Elizabeth Smith and Connie Smith Individually

Plaintiffs,

vs. LS 2441-2

RICHMOND MEMORIAL HOSPITAL,

Defendant

ORDER

On October 9, 1990 came the parties, by counsel, on the Demurrer of Defendant.

Upon consideration of the pleadings and argument of counsel and for the reasons stated in the letter opinion of this date, it is hereby Ordered and Decreed that the Demurrer is sustained without leave to amend. This case is dismissed, stricken from the docket, and

the clerk is directed to place it among the ended causes.

Endorsements pursuant to Rule 1:13 are not required, as this decision has been orally announced to the parties.

The Clerk is directed to send a certified copy of this order to all counsel of record.

ENTER: March 8, 1991

_____

Judge

## APPENDIX C

**VIRGINIA:**

*In the Supreme Court of Virginia held at the Supreme Court Building in the City of Richmond on* Friday *the* 5th *day of* June, 1992.

Taja Smith, an Infant, etc., et al., Appellants,

against Record No. 910585
Circuit Court No.
LS-2441-2/91-693

Richmond Memorial Hospital, Appellee.

Upon a Petition for Rehearing

On consideration of the petition of the appellee to set aside the judgment rendered herein on the 17th day of April, 1992 and grant a rehearing thereof, the prayer of the said petition is denied.

A Copy,

Teste:

Clerk

## APPENDIX D

42 U.S.C. § 1395dd (1988).

**§ 1395dd. Examination and treatment for emergency medical conditions and women in active labor (a) Medical screening requirement.** In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this title [42 U.S.C. §§ 1395 et seq.]) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1)) exists or to determine if the

individual is in active labor (within the meaning of subsection (e)(2)).

**(b) Necessary stabilizing treatment for emergency medical conditions and active labor.**

(1) In general. If any individual (whether or not eligible for benefits under this title [42 U.S.C. §§ 1395 et seq.]) comes to a hospital and the hospital determines that the individual has an emergency medical condition or is in active labor, the hospital must provide either----

(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical

condition or to provide for treatment of the labor, or

(B) for transfer of the individual to another medical facility in accordance with subsection (c).

(2) Refusal to consent to treatment. A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph but the individual (or a person acting on the individual's behalf) refuses to consent to the examination or treatment.

(3) Refusal to consent to transfer. A hospital is deemed to meet the requirement of paragraph (1)

with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer.

(c) **Restricting transfers until patient stabilized.**

(1) Rule. If a patient at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(4)(B)) or is in active labor, the hospital may not transfer the patient unless---

(A)(i) the patient (or a legally responsible person acting on the patient's behalf) requests that the transfer be effected, or

(ii) a physician (within the meaning of section 1861(r)(1) [42 U.S.C. § 1395x(r)(1)]), or other qualified medical personnel when a physician is not readily available in the emergency department, has signed a certification that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual's

medical condition from effecting the transfer; and

(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

(2) Appropriate transfer. An appropriate transfer to a medical facility is a transfer---

(A) in which the receiving facility--

(i) has available space and qualified personnel for the treatment of the patient, and

(ii) has agreed to accept transfer of the patient and to provide appropriate medical treatment;

(B) in which the transferring hospital provides the receiving facility with appropriate medical records (or copies thereof) of the examination and treatment effected at the transferring hospital;

(C) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(D) which meets such other requirements as the Secretary may

find necessary in the interest of the health and safety of patients transferred.

(d) **Enforcement.** (1) As requirement of medicare provider agreement. If a hospital knowingly and willfully, or negligently, fails to meet the requirements of this section, such hospital is subject to ---

(A) termination of its provider agreement under this title [42 U.S.C. §§ 1395 et seq.] in accordance with section 1866(b) [42 U.S.C. § 1395 cc(b)], or

(B) at the option of the Secretary, suspension of such agreement for such period of time as the Secretary determines to be appropriate, upon reasonable notice to the hospital and to the public.

(2) Civil monetary penalties. (A) A participating hospital that knowingly violates a requirement of this section is subject to a civil money penalty of not more than $50,000 for each such violation. The provisions of section 1128A [42 U.S.C. § 1320a-7a] (other than subsections (a) and (b)) shall apply to civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1128A(a) [42 U.S.C. § 1320a-7a(a)].

(B) The responsible physician in a participating hospital with respect to the hospital's violation of a requirement of this subsection is subject to the sanctions described in section 1842(j)(2) [42 U.S.C. § 1395u(j)(2)], except that, for purposes of

this subparagraph, the civil money penalty with respect to each violation may not exceed $50,000, rather than $2,000.

(C) As used in this paragraph, the term "responsible physician" means, with respect to a hospital's violation of a requirement of this section, a physician who---

(i) is employed by, or under contract with, the participating hospital, and

(ii) acting as such an employee or under such a contract, has professional responsibility for the provision of examinations or treatments for the

individual, or transfers of the individual, with respect to which the violation occurred.

(3) Civil enforcement.

(A) Personal harm. Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(B) Financial loss to other medical facility. Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation

of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(C) Limitations on actions. No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

(e) **Definitions.** In this section:

(1) The term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate

medical attention could reasonably be expected to result in---

(A) placing the patient's health in serious jeopardy,

(B) serious impairment to bodily functions, or

(C) serious dysfunction of any bodily organ or part.

(2) The term "active labor" means labor at a time at which---

(A) delivery is imminent,

(B) there is inadequate time to effect safe transfer to another hospital prior to delivery, or

(C) a transfer may pose a threat of the health and safety of the patient or the unborn child.

(3) The term "participating hospital" means hospital that has entered into a provider agreement under section 1866 [42 U.S.C. § 1395cc].

(4)(A) The term "to stabilize" means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from the transfer of the individual from a facility.

(B) The term "stabilized" means, with respect to an emergency medical condition, that no material

deterioration of the condition is likely, within reasonable medical probability, to result from the transfer of the individual from a facility.

(5) The term "transfer" means the movement (including the discharge) of a patient outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of a patient who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

(f) **Preemption.** The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

Va. Code Ann. § 8.01-581.2
(Repl. Vol. 1992)

§ 8.01-581.2. **Notice of claim for medical malpractice required; request for review by medical malpractice review panel; rescission of request; determination on request.** -- A. No action may be brought for malpractice against a health care provider unless the claimant notifies the health care provider in writing by registered or certified mail prior to the commencing the action. The written notification shall include the time of the alleged malpractice and a reasonable description of the act or acts of malpractice. The claimant or health care provider may within sixty days of

such notification file a written request for a review by a medical malpractice review panel established as provided in § 8.01-581.3. The request for review shall be mailed to the Chief Justice of the Supreme Court of Virginia. Upon receipt of such request, the Chief Justice shall designate one sitting or one retired circuit court judge to act as chairman of the panel and shall select the other panel members as provided in § 8.01-581.3:1. No actions based on alleged malpractice shall be brought within ninety days of the notification by the claimant to the health care provider and if a panel is requested within the period of review by the medical review panel.

B. Whenever the requesting party rescinds a request for review by a medical malpractice review panel, notice of such rescission shall be given to counsel for the opposing party at the time notice is given to the Chief Justice of the Supreme Court.

C. Notice of the determination of the Chief Justice on a request for review shall be given to counsel for both parties.

D. If a claim arising out of the same incident is asserted against more than one health care provider, the notice of claim shall name all of them and shall be filed with all of them. Any health care provider so named shall have the

right to request a panel and, in that event, shall mail copies of its request to the other health care providers named in the notice of claim as well as to the claimant and his counsel of record. When a request for a medical review panel is made by any party, a single panel shall be designated and all health care providers against whom a claim is asserted shall be subject to the jurisdiction of such panel. The provisions of this subsection shall not prohibit the addition of parties pursuant to § 8.01-581.2:1.

# APPENDIX E

DEPARTMENT OF HEALTH
AND HUMAN SERVICES

Health Care Financing
Administration

Regional Office VI
1200 Main Tower Building
Dallas, Texas 75202

January 29, 1992

REGIONAL HEALTH STANDARDS AND QUALITY
LETTER NO. 92-08

TO: All State Survey Agencies (Action)
All State XIX Single State Agencies
(Information)

SUBJECT: Enforcement of the Anti-Dumping Provisions of Section 1867 of the Social Security Act (the Act)

This statement sets forth the anti-dumping enforcement procedures as they apply to State Survey Agencies (SAs), based upon

information provided to us by the Health Standards and Quality Bureau. Our purpose is to outline the anti-dumping provisions in the statute and not to establish rules, subject to the notice and comment provisions of the Administrative Procedures Act.

These instructions may be modified, as necessary, in accordance with the forthcoming final regulations. In addition, attached are copies of section 1867 and pertinent parts of section 1866

and section 1154, as well as physician review forms.

Sincerely,

Kenneth C. Schneider, M.D.,
Associate Regional
Administrator for Health
Standards and Quality

ENFORCEMENT PROCEDURES

A. SCOPE

The underlying concept of section 1867 of the Act is "equal treatment." With the passage of section 1867 in 1986, Congress intended that all individuals would have equal access to emergency treatment in hospitals having Medicare provider agreements. They intended this even if the individual could not pay for the treatment, did not have medical insurance, and was not enrolled in Medicare or eligible for Medicaid.

Accordingly, when an individual comes to a hospital with an emergency department and

seeks treatment, he or she must be screened to determine if an emergency medical condition exists. If so, the hospital must provide, within its staff and facilities available, for further medical examination and treatment to stabilize the medical condition, or for transfer of the individual to another medical facility in accordance with section 1867(c)(2).

All provisions of the anti-dumping statute, including the documentation and transfer requirements, are applicable once an individual with an emergency medical condition or a woman in labor presents him or herself and requests services at a

Medicare participating hospital that has an emergency department. The anti-dumping requirements continue to apply until the individual is properly examined, treated, stabilized and, if appropriate, either admitted to the hospital, discharged, or properly transferred, unless the individual or his/her representative refuses any of those services. This does not mean that the anti-dumping provisions apply to all hospital transfers. Once an individual's emergency medical condition is stabilized as defined under section 1867(e)(3) the hospital has met its obligations under this statute and it no longer is required to comply with the other anti-dumping documentation or

transfer requirements. However, until the individual is stabilized, the hospital is obligated to comply with all provisions of the anti-dumping statute. In such a case, the documentation and transfer requirements would apply without regard to the hospital unit that initiates a transfer or to where the patient is transferred.

B. SECTION 1866 OBLIGATIONS

Section 1866 includes four (4) requirements related to section 1867. Hospitals must comply with these requirements in order to participate in the Medicare and Medicaid programs.

1. Section 1866(a)(1)(I)(i) - requires a hospital to have and enforce policies to ensure compliance with the requirements of section 1867.

2. Section 1866(a)(1)(I)(ii) - requires a hospital to maintain medical and other records related to individuals transferred (including discharged) to or from the hospital for a period of 5 years from the date of the transfer.

3. Section 1866(a)(1)(I)(iii) - requires a hospital to maintain a list of physicians who are on call to provide treatment necessary to stabilize an individual with an emergency medical condition.

4. Section 1866(a)(1)(N)(iii) and (iv) - requires a hospital to post conspicuously a sign(s) specifying the rights of individuals, under section 1867, with respect to examination and treatment for emergency medical conditions and women in labor and to indicate whether or not the hospital participates in the Medicaid program.

C. SECTION 1867 OBLIGATIONS

Section 1867 places six (6) requirements on hospitals that have an emergency department. Hospitals must comply with these requirements to participate in the Medicare and Medicaid programs.

1. Section 1867(a) - Screening - requires a hospital to screen all individuals who come to the hospital and request an examination or treatment for a medical condition. The medical screening examination must be appropriate and within the hospital's capability, including ancillary services routinely available, to determine whether or not an emergency medical condition exists.

2. Section 1867(b) - Treatment - requires that once a hospital determines that the individual has an emergency medical condition, it must provide either further medical examination and such treatment as may be required to stabilize the medical condition, within the staff

and facilities available at the hospital, or transfer in accordance with the requirements of section 1867(c).

3.a. Section 1867(c)(1) - Transfer - prohibits a hospital from transferring an individual with an emergency medical condition which has not been stabilized unless (1) the individual (or legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, requests transfer, in writing, to another medical facility; or, (2) a physician has signed a certification that based on the information available at the time of transfer, the medical benefits reasonably

expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer; or (3) if a physician is not physically present in the emergency department at the time the individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification, in consultation with a physician who subsequently signs the certification, stating that the medical benefits reasonably expected from the provision of appropriate medical treatment at another

medical facility outweigh the increased risks to the individual.

3.b. Section 1867(c)(2) - requires a hospital to effect an <u>appropriate</u> transfer if the individual has an emergency medical condition that has not been stabilized. The hospital may not transfer the individual unless the individual requests transfer or a physician certifies the medical necessity of the transfer.

To make an appropriate transfer the transferring hospital must (1) provide the medical treatment, within its capacity, which minimizes the risk to the individual; (2) send all pertinent medical records available, at the time of

transfer, to the receiving hospital; (3) effect the transfer through qualified personnel and transportation equipment, including necessary life support measures; and (4) obtain the consent of the receiving hospital.

NOTE: Once a physician determines and documents that an individual has been stabilized pursuant to section 1867(e)(3) of the Act, the anti-dumping statute does not impose any additional requirements on a transferring hospital that are not already required by other Federal, State or local laws. In such situations, once the hospital has complied with the examination,

treatment and stabilization requirements of the statute, it has met all of the anti-dumping statutory requirements.

4. Section 1867(g) - Nondiscrimination - prohibits a hospital with specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units) from refusing to accept an appropriate transfer of an individual who requires those specialized capabilities if the specialized hospital has the capacity to treat the individual.

5. Section 1867(h) - No delay in examination or treatment - prohibits a hospital from delaying a medical screening

examination or stabilizing treatment in order to inquire about an individual's method of payment or insurance status.

NOTE: Regardless of whether a hospital will be paid, it is obligated to provide the services specified in section 1867.

6. Section 1867(i) - Whistleblower protections - provides whistleblower protections to physicians who refuse to authorize the transfer of an individual who has not been stabilized. It also provides whistleblower protections to qualified medical personnel who refuse to authorize the transfer of an individual with an emergency medical condition, that has not been stabilized, and to any

hospital employee who reports a violation of section 1867.

D. DEFINITIONS

1. Capability - means the services a hospital provides (e.g., psychiatry, obstetrics, intensive care, trauma care).

2. Capacity - means the ability of the hospital to accommodate an individual in need of examination or treatment. Capacity encompasses such things as numbers and availability of qualified staff, beds and equipment.

3. Emergency medical condition - means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that

the absence of immediate medical attention could reasonably be expected to result in (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to any bodily function, or (3) serious dysfunction of any bodily part.

- Psychiatric emergency - the statute provides a definition of an emergency medical condition; it does not provide a separate definition of a psychiatric emergency. For a psychiatric condition to be considered an emergency, it must meet the general requirements of an

emergency as defined above and in Section 1867(e)(I).

- Pregnant woman who is having contractions - has an emergency medical condition if there is an inadequate amount of time to effect a safe transfer to another hospital before delivery, or if the transfer may pose a threat to the health or safety of the woman or the unborn child. If the pregnant woman has an emergency medical condition, the hospital must either deliver the baby, including the placenta, or effect an appropriate transfer.

4. Labor - means the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta.

5. On-call physician list - means a list of physicians maintained by the hospital, as required by section 1866, who are available after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition.

6. Specialized capabilities or facilities - for the purpose of the non-discrimination provision of section 1867(g) means capabilities or facilities such as burn units, shock-trauma units, neonatal intensive care units, or (with

respect to rural areas) regional referral centers as identified by the Secretary in regulation.

7. Stabilize - means to provide such medical treatment necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result or occur during the transfer or that a woman in labor has delivered, including the placenta.

8. Transfer - means the movement, including the discharge, of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does

not include such a movement of an individual who has (A) been declared dead, or (B) leaves the facility without the permission of any such person.

* * * * *

G. Evaluation of the applicability of section 1867

1. 42 CFR section 482.12(f) - hospitals that have emergency departments are subject to section 1867 and the anti-dumping provisions of section 1866. Hospitals that do not have emergency departments must still have written policies and procedures for appraisal of emergencies, initial treatment,

and referral when appropriate, and must comply with the Conditions of Participation in this regard.

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## APPENDIX F

# Medicare Requirements for Emergency Services and Transfers

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Special Member Briefing

October 1990

American Hospital Association

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## Purpose of the Guide

The OBRA 89 requirements took effect on July 1, 1990, even though no final regulations have been issued by HCFA to govern implementation. HCFA has issued instructions about the posting of signs, but otherwise has not developed any guidelines to explain new terms or ambiguous provisions of the statute. Consequently, hospitals must base their compliance action on the statute. AHA has been working with many member hospitals on revising emergency department procedures to comply with the spirit as well as the letter of the law. This guide, which is based on the most frequently asked questions, grew out of our efforts to clarify the meaning of the new law and to help hospitals operationalize and

demonstrate their compliance with the requirements.

The information contained in this guide does not constitute legal advice. These interpretations are based on a close reading of the law by AHA staff, without benefit of HCFA final regulations. Each hospital should consult with legal counsel when assessing its compliance with the new requirements. While the interpretations offered here represent a reasonable approach to implementing the new requirements, they may not match policy decisions that emerge in subsequent regulations or through hospital enforcement actions.

In an effort to answer some of the more frequently asked questions about interpretation of the new provisions, AHA sent a letter to Gail Wilensky, Ph.D., Administrator of HCFA, requesting clarification of a number of issues. AHA received a response to its inquiry on September 15, 1990, basically confirming the interpretations outlined in the July 9 letter and elaborated on in this briefing. Several important issues nevertheless remain unresolved. Copies of both AHA's letter to Dr. Wilensky and her recent response (Reference No. 90-30) are available from the AHA Resource Center at 312/280-6263.

* * * * *

**Do the transfer protocols have to be observed for hospital inpatients?**

No. Taken together, these requirements describe a series of steps for the identification and treatment of individuals who come to a hospital's emergency department seeking care for an emergency medical condition. Many hospitals have questioned whether the requirements for transfer in this law would apply to hospital inpatients who develop emergency medical conditions and may need to be transferred to another facility. The logic of the law as just described suggests that it does not pertain to the transfer of hospital inpatients. This does not preclude the possibility that subsequent court judgments may apply the transfer

protocols in cases involving inpatients and some hospitals may wish to adopt this broader interpretation pending further judicial action.

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# APPENDIX G

American Hospital Association

Capital Place, Building #3
50 F Street N.W.
Suite 1100
Washington, D.C. 20001
Telephone (202) 638-1100
Fax No. (202) 626-1345

HAND DELIVERED

July 9, 1990

Gail R. Wilensky, Ph.D.
Administrator
Health Care Financing Administration
200 Independence Avenue, S.W. -
Room 309-G
Washington, D.C. 20201

Re: Implementation of OBRA 1989 Revisions to Patient Transfer Requirements

Dear Dr. Wilensky:

As you know, the Omnibus Budget Reconciliation Act of 1989 (OBRA) amended the requirements for Medicare-

participating hospitals offering emergency services. Hospitals now must:

- post signs in their emergency rooms explaining their responsibilities in emergencies;

- make reasonable efforts to obtain from patients written informed consents to transfer or refusals of treatment;

- not delay a medical screening examination or stabilizing treatment in order to inquire about payment or insurance status;

- maintain a roster of on-call physicians to furnish stabilizing treatment in the emergency room;

- assure that a physician certifies transfer decisions and identifies the attendant risks;

- accept transfers from other hospitals, if they have specialized capabilities and capacity.

These new requirements took effect on July 1, 1990, in spite of the fact that regulations have not yet been issued to implement them. In fact, no regulations have been issued to date to implement the original requirements contained in the

Consolidated Omnibus Budget Reconciliation Act of 1985.

Instructions concerning the sign requirements in the OBRA provisions have been developed and circulated by HCFA, with sample language for the signs to be posted in emergency rooms. However, we understand that no other regulations or instructions to clarify hospital obligations under the new law are forthcoming. In the absence of any guidance from HCFA, each hospital must develop policies and procedures based on its own interpretation of the law.

Although the basic structure of the statutory provisions appears generally consistent with the standard hospital

protocol for handling emergency patients, several questions have arisen about the meaning of key provisions and the extent of new obligations actually imposed on hospitals under the new law. Hospitals are therefore uncertain about whether they have to restructure their emergency room policies and procedures to assure their compliance with the new requirements. In particular, our members have raised questions abut the following requirements:

- to treat emergency patients;

- to provide a medical screening examination "within the capability of the emergency department";

- to provide "stabilizing treatment" to individuals with emergency medical conditions;

- not to delay screening or stabilizing treatment to gather information about the individual's insurance status;

- to maintain a roster of on-call physicians;

- for on-call physicians to appear within a "reasonable period of time" to stabilize an individual with an emergency medical condition; and

- for specialized facilities to accept transfers.

In the following sections, we raise our members' questions about each of these issues and suggest what we believe the plain language of the statute requires. We believe that these are sound interpretations and, in the absence of regulations, offer reasonable guidance to our members on how to ensure compliance with the statute. For this reason, we would appreciate your reactions to this advice and, in particular, any problems that you foresee if our members follow it.

Scope of Required Treatment Under Sec. 1867

As we understand the statute, hospitals have the following obligations toward any individual who comes to the emergency room. A hospital with an emergency department must provide a medical screening examination to determine whether an emergency medical condition exists. If the individual has an emergency medical condition, a hospital must either stabilize the individual's condition or provide for an "appropriate" transfer. Transfer of an unstable individual can be undertaken if the individual requests the transfer in writing after being informed of the hospital's obligations and of the risks of transfer, or if a physician, or qualified medical person in consultation

with a physician, concludes that the medical benefits of treatment at another facility outweigh the increased risks of transfer to that facility.

The provisions of Sec. 1867 pertain only to the treatment of emergencies and, in particular, the protocol for handling transfers. The Medicare statute does not address the extent of a hospital's obligation to treat individuals beyond emergency situations. Those obligations are established through case law and other programmatic regulations, like those for the Hill-Burton program, which oblige hospitals to provide services to individuals who cannot afford to pay for their care.

Medical Screening Examination

Section 1867(a) of the Social Security Act (the Act) requires hospitals to furnish a medical screening examination "within the capability of the hospital's emergency department." The statute specifies that "the capability of the hospital's emergency department" includes "ancillary services routinely available to the emergency department." Hospitals seek clarification, however, on how extensive this medical screening examination must be.

According to the statute, the purpose of the medical screening examination is to determine whether an individual who comes to the emergency department has an

emergency medical condition. Therefore, the required examination is that which is necessary to determine whether an emergency exists. A simple examination by a triage nurse would be sufficient in some cases, whereas in other cases a more extensive medical evaluation would be necessary, including diagnostic tests, depending on the patient's condition.

In the context of the medical screening examination, we believe the plain meaning of the phrase "within the capability of the hospital's emergency department" encompasses only those services that are available to any emergency patient at the time the emergency department visit occurs. This would mean, first, that all individuals in the emergency room would

have access to the same services. But it also means that hospitals retain the right to define the scope of services available to the emergency department. We do not believe that these provisions require hospitals to expand their emergency department capabilities beyond what they generally (or "routinely") make available to all emergency patients through the emergency room. Some services cannot be made available through the emergency room or are available only during certain hours because staff are not available at all times. For example, computerized tomography or complex radiology procedures may be available only when a neurologist or radiologist is available to administer the procedure.

Providing Stabilizing and Risk Minimizing Treatment

Section 1867(b)(1)(A) now requires a hospital to provide further medical examination and "such treatment as may be required to stabilize" an emergency medical condition "within the staff and facilities available at the hospital." To "stabilize" is defined in Sec. 1867(a)(3)(B) to mean that no "material deterioration of the condition" is likely, "within reasonable medical probability," to result from or occur during a transfer.

How much treatment is required to stabilize an individual's emergency medical condition? The answer depends upon the medical condition involved. For example, a woman in labor is defined as

having an emergency medical condition if there is inadequate time to safely transfer, or the transfer poses a threat to the woman or unborn child's health. In such a case, "stabilization" would require delivery of the baby. Stabilization of other emergency medical conditions would require hospitals to mitigate the emergency, but not necessarily to eliminate the underlying clinical condition. For example, a patient with chest pains who is determined to have a possibly fatal arrythmia could be stabilized with medications sufficient to allow further care of the underlying heart disease that led to the emergency. In some cases, as with chronic conditions, stabilization of the emergency may represent the full

extent of treatment. For example, an emergency asthma attack may be fully treated with drugs which open the airway.

If the decision is made to transfer an unstabilized patient, the hospital must provide "medical treatment within its capacity to minimize the risks." For example, a trauma victim with serious soft tissue damage and an open bone fracture of the leg might be injured beyond the capabilities of the average emergency room physician. The emergency room physician in this case might minimize the risk of transfer by cleaning the wound, stanching the bleeding, securing the leg, and making the individual as comfortable as possible for transfer to an institution where an

orthopedist would be available to set the leg and perform any necessary surgery.

Many providers have expressed particular concern over obstetric emergencies. We feel that it is important to note that the statute distinguishes between women in labor who have an emergency medical condition, and those who do not. The law does not require delivery with regard to every woman in labor presenting at the emergency department. Rather, delivery must occur if an emergency condition exists, which, as discussed above, is defined as where there is inadequate time to transfer or transfer poses a health risk.

Hospitals have also asked how these concepts would apply to psychiatric emergencies. While not specifically addressed in the statute, the notion of "stabilization" can be applied to psychiatric conditions. "Emergency medical condition" is defined in Sec. 1867(a) in relation to physiological danger only. In the context of psychiatric emergencies, an emergency condition exists when an individual presents an immediate physical threat to himself or others. Stabilizing treatment for these patients would entail those actions necessary to remove that threat, albeit temporarily, so that the danger which constitutes the emergency is removed, even though the underlying

psychiatric problem may not be eliminated.

Maintaining a List of On-Call Physicians

Section 1866(a)(1)(I)(iii) requires hospitals to maintain a roster or schedule of physicians who are on call for duty after the initial examination to provide stabilizing treatment. Questions have been raised about whether this provision requires all physicians to provide on-call services to hospital emergency departments or requires hospital emergency departments to expand on-call coverage to include all medical services available to the hospital around the clock.

We interpret this provision to mean that a hospital must ensure 24-hour coverage of the emergency room by at least one physician through an on-call roster of the medical staff, but it does not require that every physician be on-call. This would be consistent with Joint Commission standards for emergency departments (AMH Standard BR.1.4.3). We believe that hospitals are required to stabilize individuals using the resources available when the individual comes to the emergency department and that the hospital retains the right to define the scope of services that would generally be offered through its emergency room, which will not necessarily involve all medical specialties represented on the entire medical staff.

The requirement for maintaining a list of on-call physicians to provide stabilizing treatment does not mean that every physician on the medical staff must be available on-call for emergency room duty or that all services must be accessible around the clock. Some specialized services cannot be staffed around the clock. In some areas, a small hospital may have a single orthopedic surgeon or other specialist whom it shares with other hospitals, limiting the basis on which it can offer the service. If an individual's condition requires treatment exceeding the level of services immediately available through the emergency department, the emergency department physician or other qualified medical person would have to take this

into account in making a decision as to whether to treat or transfer.

Failure to appear within a "reasonable period of time"

Section 1867(d)(2)(C) offers liability protection to a physician who authorizes a transfer after determining that the benefits of transfer exceed the risks, when an on-call physician fails or refuses to appear "within a reasonable period of time." The on-call physician who failed or refused to appear and the hospital could, however, be liable. This raises the question of what constitutes a reasonable period of time in which to appear for duty to stabilize individuals with an emergency medical condition.

We believe that "reasonable period of time" must be understood both in terms of the time within which an on-call physician may be expected to arrive at the hospital and the time within which the treating physician must make a transfer decision even when an on-call physician is en route. What constitutes a reasonable period of time therefore depends upon the nature of each individual's emergency condition. It would therefore be inappropriate to establish an arbitrary time within which an on-call physician would be expected to appear.

We believe further that there are circumstances when it would be inappropriate to impose a penalty for a

physician's failure to appear within a "reasonable period of time." Legitimate reasons that an on-call physician might fail to appear include the urgent need to perform another medical procedure or unavoidable traffic delays that prevent prompt arrival at the facility. Such legitimate reasons for failing to appear should constitute appropriate grounds for exemption from liability, and penalties should apply to neither the hospital nor the on-call physician when the physician is contacted but unable to appear.

Capacity of Specialized Receiving Facility to Treat Transfers

According to Sec. 1867(g), a hospital with specialized capabilities or facilities (for example, a shock/trauma

unit, burn unit, or cardiac intensive care unit) cannot refuse to accept an appropriate transfer of an individual needing such specialized treatment if the hospital has the capacity to treat the individual.

Several hospitals have questioned the meaning of "capacity" to treat. We believe that a hospital would be obligated to accept a transfer patient who needs its specialized services or facilities if it has the immediate ability to treat the individual, but not if personnel are unavailable at the time transfer is requested, equipment is in use, or facilities are filled to capacity. We believe the statute obligates hospitals to accept patients

needing its specialized services or facilities only to the extent that they need those specialized services and only to the extent that there is room in the specialized unit to treat them. Receiving facilities are obligated to treat the emergency only as long as the specialized facilities or capabilities are needed.

Inquiries about Insurance Status During Emergencies

Section 1867(h) prohibits a hospital from delaying the medical screening examination or any necessary stabilizing treatment to determine an individual's insurance status or method of payment. At what point, then, can the hospital gather information from the individual,

including information about the individual's insurance status?

The statute is clear on this point, if not precise. Hospitals may inquire about an individual's insurance status at any time as long as the initial screening and stabilizing treatment are not delayed in order to obtain the information. The statute would prevent the delay of not only the screening examination, but also any stabilizing treatment required.

We do not believe this section should be construed as prohibiting the collection of any financial information, particularly from the family, while care is being provided to the individual or

while a patient is in a queue for diagnostic tests.

Conclusion

AHA appreciates the seriousness of the patient transfer requirements. The statute is designed to provide safeguards against the very infrequent medically inappropriate transfer, and not to prohibit or even inhibit appropriate transfers. We believe that our suggestions represent a sensible interpretation of the new requirements and that for most hospitals, compliance should require no radical changes in the way they currently treat individuals with emergency medical conditions.

Aggressive enforcement of the original patient protection provisions in some regions, combined with the lack of guidance on the meaning of the new requirements, has raised the level of anxiety among hospitals and created some confusion about what hospitals should be doing to implement the new law. We need some indication that HCFA agrees with our interpretations of the new provisions so that our members can be assured that their policies and procedures comply with the law. We also urge HCFA to reflect these interpretations in its own regulations implementing the patient transfer requirements and hope that those regulations will be forthcoming in the near future.

If you have additional questions about the issues outlined above, please contact Thomas Granatir (312/280-6183) in our Chicago office or Gaelynn DeMartino (202/636-2361) in our Washington office.

Sincerely

Paul C. Rettig
Executive Vice-President

## APPENDIX H

DEPARTMENT OF HEALTH
AND HUMAN SERVICES

Health Care Financing Administration

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September 17, 1990

The Administrator
Washington, D.C. 20201

Mr. Paul C. Rettig
Executive Vice-President
American Hospital Association
Capitol Place, Building #3
50 F Street, N.W., Suite 1100
Washington, D.C. 20001

Dear ~~Mr. Rettig~~ Paul:

I am responding to your letter requesting written verification from the Health Care Financing Administration (HCFA) that your interpretations of the statute's anti-dumping provisions, as

amended by the Omnibus Budget Reconciliation Act of 1989 (OBRA 89), are correct and can be used to offer reasonable guidance to your member hospitals on how to ensure compliance.

As you know, a proposed rule with comment period that would implement section 1867 of the Social Security Act (the Act) was published June 16, 1988, in the Federal Register at 53 FR 22513. After receiving extensive public comments, we developed a final regulation. However, Congress passed OBRA 89, which amended and added new requirements to the anti-dumping provisions. We have, therefore, been rewriting the final regulation to

incorporate these new statutory requirements. We expect to publish a final regulation, with the opportunity for further public comment, within the next few months.

I am sure you understand that, as with all Federal regulations, instructions and guidelines, we cannot develop and write policies which explicitly address all possible situations that can arise. We can only develop and write policies and guidelines which will set overall, general rules for the application of the statutory provisions. They are used by Medicare participating providers and Federal surveyors to analyze and judge medical

emergency situations in accordance with the intent of Congress which, in this case, is to protect the health and safety of emergency medical patients and women in labor. I can state, though, that your basic understanding of the intent and application of these provisions is correct. In this letter, I will try to give you as much guidance as I can at this time concerning the issues you have raised. We believe as you do that hospitals which have been showing good faith efforts in handling emergency situations and operating under standard hospital protocols will not find it necessary to make significant changes in

their emergency room policies and procedures to comply with the anti-dumping requirements.

I want to preface my replies to your questions by indicating that each individual situation will have to be reviewed. Our assessments will be based upon all the information existing at the time of the emergency situation within the overall guidelines of the final anti-dumping regulation. Except for the specific items cited below, we concur with your basic understanding of the application of the statute's anti-dumping provisions. Please keep in mind, though, that the final regulation specifying the

requirements must still undergo final review and clearance. There may be changes in our interpretations of these requirements as a result of that review.

Your understanding of the scope of required treatment under section 1867 of the Act is correct. However, we would also note the statutory requirement for physicians or qualified medical personnel to sign a certification to the effect that the reason for the transfer outweighs the increased risks of transfer to another facility.

Your interpretation of section 1867(a) of the Act regarding medical screening examination requirements, while

written to stress the statutory limits of a hospital's obligations, is correct. The key is the requirement that services be available, including ancillary services, that would be available generally to the hospital's emergency patients. While it is true that some sophisticated services may not be available at all hours, it is also true that the inability to use such services may necessitate further observation or admission of a patient who requires such services for the diagnosis or treatment of his or her emergency medical condition or labor.

We agree with your general interpretations of sections 1867(b)(1)(A)

and 1867(c) of the Act regarding stabilizing and risk minimizing treatment requirements, including your discussion of psychiatric emergencies.

Our response to the issue regarding section 1866(a)(1)(I)(iii) of the Act regarding on-call physicians lists is similar to the one we previously gave concerning medical screening examination requirements. We believe that during a hospital's normal operating hours all medical specialties represented on the medical staff should be available for emergency services. However, it would not be reasonable to require this type of coverage when ancillary departments are

ordinarily not in operation, such as Sundays and holidays.

I hope this information will assist your member hospitls to better understand and comply with the anti-dumping statutory requirements and, thereby, reduce confusion and anxiety.

Sincerely,

Gail R. Wilensky, Ph.D.
Administrator

# APPENDIX I

DEPARTMENT OF HEALTH
AND HUMAN SERVICES

Health Care Financing Administration

Refer to: EQA-812

6325 Security Boulevard
Baltimore, MD 21207

August 14, 1990

Mr. R. Mark Hodges
Wise, Carter, Child and Caraway
Professional Association
600 Heritage Building, P.O. Box 651
Jackson, Mississippi 39205

Dear Mr. Hodges:

I am responding to your letter requesting a written statement from the Health Care Financing Administration (HCFA) as to whether the provisions of section 6018, Hospital Anti-Dumping Provisions, of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89), Public Law 101-239, apply

only to hospitals with emergency departments or whether they apply to all provider hospitals. You also asked that if the section 6018 provisions apply to all hospitals, do they thereby make the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA '85), Public Law 99-272, the original anti-dumping statute, also apply to all hospitals, not just hospitals with emergency departments.

As I advised you during our telephone conversation, it is HCFA's position that all provisions of the anti-dumping statutes, including all COBRA '85 and OBRA '89 provisions, do not apply to all Medicare participating hospitals. They only apply to Medicare participating

hospitals with emergency departments. As indicated in the very first sentence of section 1867 of the Social Security Act, as established by COBRA '85, the anti-dumping requirements apply, "In the case of a hospital that has a hospital emergency department . . ." We base our position that section 6018 of OBRA '89 does not expunge the "hospital emergency department" language of section 1867 upon the language of subsection 6018(a)(1)(I)(i) which directs Medicare participating hospitals "to adopt and enforce a policy to ensure compliance with the requirements of section 1867."

We read this language to mean that section 6018, and all other OBRA '89 provisions, extend the original COBRA '85

anti-dumping requirements, including the requirements which specify to which Medicare providers the provisions apply.

Sincerely yours,

Thomas E. Hoyer, Jr.
Director, Division of Provider
Services Coverage Policy
Office of Coverage
and Eligibility Policy
Bureau of Policy Development